

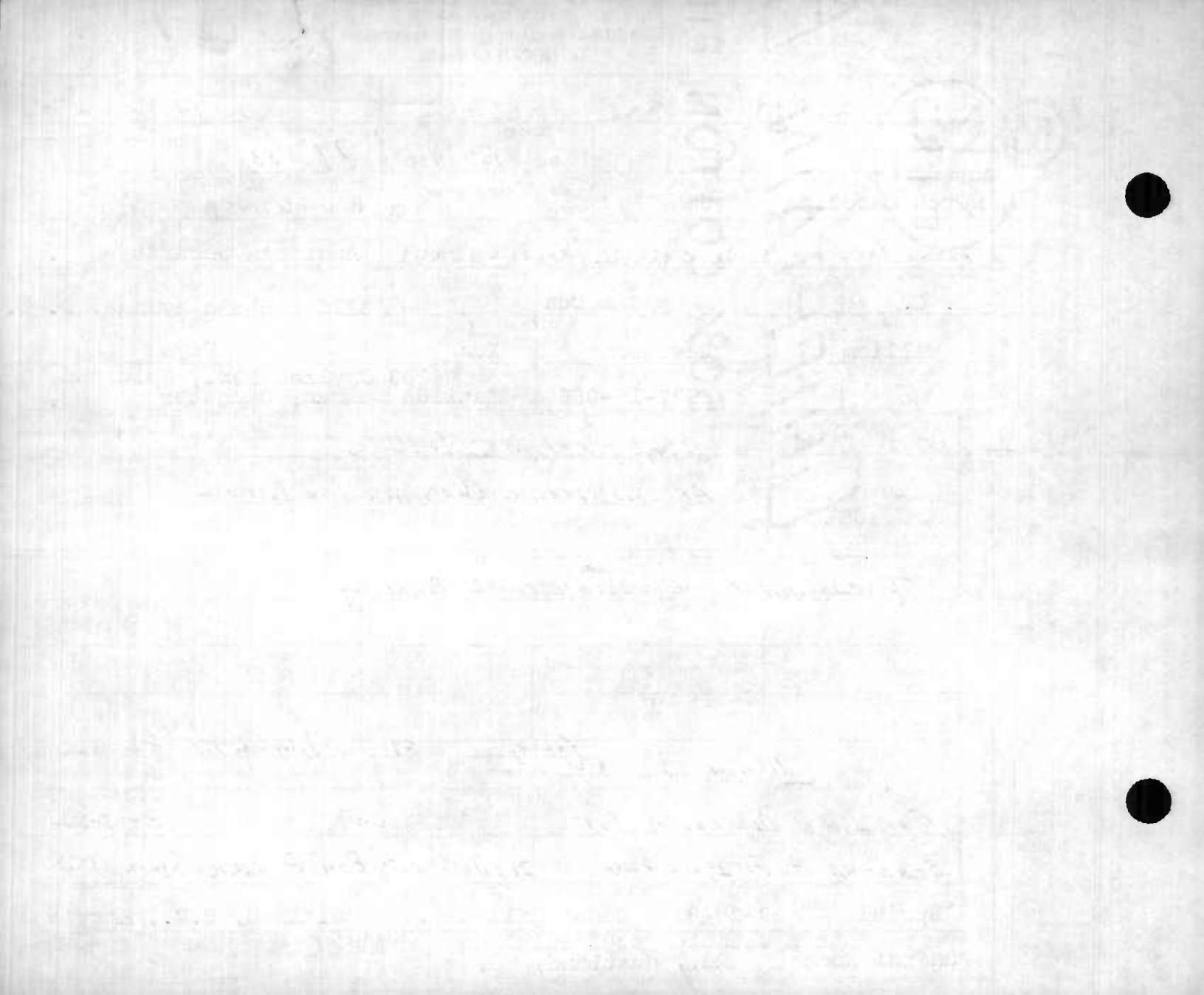
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LETHA MAE ARSHER					2a. DATE OF DEATH MONTH DAY YEAR 03 17 82				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 08 15 94		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		2b. HOUR 2:05 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY 15 MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SLIGO GARDENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) American Security-Off.		12b. KIND OF BUSINESS OR INDUSTRY Clerk	
13a. STATE D. C.		13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3229 Alabama Avenue, S. E.	
14. FATHER'S NAME FIRST MIDDLE LAST William Davidson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Frye				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-16-06584		17. INFORMANT ADDRESS 6203 Skyline Ter., Suitland, Md. Matilda Seaman, Daughter					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) PNEUMONITIS, GASTROINTESTINAL BLEEDING									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 81 to March 17 19 82 that (we) last saw the deceased alive on March 17 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3-17-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-20-82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland			
24. FUNERAL DIRECTOR NAME Robt E wilhelm Funeral Home				4308 Suitland Rd., Suitland, Md.		25a. DATE OF DEATH MAR 24 1982		25b. REGISTRAR'S SIGNATURE James J. Kathan	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 3 9 6

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) John W. ADDISON			2a DATE OF DEATH MONTH 3 DAY 12 YEAR 82		2b HOUR 10⁰⁸ AM
3 SEX MALE	4 RACE BLACK	5 DATE OF BIRTH MONTH OCT. DAY 18 YEAR 1907	6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS 	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH Silver Spring	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD	13b COUNTY Montg.	13c CITY OR TOWN Silver Spring	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 11812 Metone Rd.	
14 FATHER'S NAME FIRST Norah MIDDLE Addison LAST Addison	15 MOTHER'S MAIDEN NAME FIRST Alcinda MIDDLE Proctor LAST Proctor		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
16b SOCIAL SECURITY NO. 212-14-5101		17 INFORMANT ADDRESS 1001 Norwood Rd. Leroy Addison (SON) Silver Spring, MD.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Septic Shock**APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
48 hours**5130**Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) **Left empyema**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Left Lung abscess**PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NO**

MEDICAL CERTIFICATION

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from Mar 10 19 82 to Mar 12 19 82 , that (I) (we) last saw the deceased alive on Mar 12 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) had examined the body after death.			
22b SIGNATURE Kenneth G. Mason	22c DEGREE MD	22d PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth G. Mason	22e ADDRESS c/o Holy Cross Hospital, Silver Spring Md.
22f ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22g DATE SIGNED 3/12/82	

23a BURIAL, CREMATION, REMOVAL Burial	23b DATE 3-16-82	23c NAME OF CEMETERY OR CREMATORY Ash Mem. Cem.	23d LOCATION CITY OR TOWN COUNTY STATE Sandy Spring Montg Md.
24 FUNERAL DIRECTOR NAME George R. Snowden ADDRESS 246 N. WASH. ROCKVILLE, MD.		25 DATE REC'D. BY REGISTRAR MAR 16 1982	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 0 7 3 9 1 (3-4-82)									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Aiton		B.		Aiford		SR.		3/4/82		4 5 50 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		3 29 1906		75		YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Wash., D. C.		U. S. A.				Montgomery				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Adventist Hosp		Retired-Dist. Store		Grocery				House	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Montgomery		Sil. Spr.				415 Silver Spring Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Delis		Alford		Charlotte		Pinkney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE)		17. INFORMANT ADDRESS							
No		---		578-03-5913		Bessie I. Alford Sil. Spr., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic obstructive Pulmonary disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Infarction</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Conduction system</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25/82</u> to <u>3/4/82</u> , that (I) (we) last saw the deceased alive on <u>3/4/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
VIVEK C VAID		7676 New Hampshire Ave									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		3/8/82		Ft. Lincoln Cemetery		Brentwood				Md.	
24. FUNERAL DIRECTOR OR NAME		ADDRESS		DATE RECEIVED BY REGISTRAR		REGISTERED SIGNATURE					
Warner E. Pumphrey, Inc.		P. O. Box 7428		MAR 8 1982		Frances Jan					

W. B. 1000

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 7 3 9 8
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) Elley J. Allekand			2a. DATE OF DEATH March Month 16 Day 1982 Year			2b. HOUR 10:30 M			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH SEPT. 22, 1896		6. AGE (In years last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) ESTONIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY COUNTY Md.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) NATIONAL LUTH. HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 11129 - Stephalee La.,	
14. FATHER'S NAME First JURI Middle KRUHLBERG Last WENDT			15. MOTHER'S MAIDEN NAME First LENA Middle WENDT Last WENDT			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 324-44-5875T			17. INFORMANT Address ROCKVILLE, MD REV. DR. RICHARD REICHARD - NLH-9701-VEIRS DR.,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coriatic arrest 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Cardio-Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) 5 yr								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Feb 27, 1981 to March 16, 1981 , that (I) (we) lost saw the deceased alive on March 16 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold F. M. Cann M.D. DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED MARCH 16, 1982		
22d. PHYSICIAN'S NAME (Type) HAROLD F. M. CANN					22e. ADDRESS 3355-16th St. N.W. WASH. D.C.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE MARCH 19, 1982		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) SUITLAND, MARYLAND			
24. FUNERAL DIRECTOR HYSONG FUNERAL HOME- 1300-N ST., NW WASH., DC					25. REC'D BY REGISTRAR MAR 29 1982		25c. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 3 9 9 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Guy F. Allnutt				2a DATE OF DEATH MONTH DAY YEAR March 15, 1982				2b HOUR 11 15 P.M.			
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Jan, 27 1894		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.	
9a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retail-owner		12b KIND OF BUSINESS OR INDUSTRY General Store			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 9701 Fields Road			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph N Allnutt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucie Williams							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b SOCIAL SECURITY NO. 220 32 5525		17 INFORMANT ADDRESS Sally Dorset, Box 127, Poolesville, Md					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction + Cardio-Respiratory arrest</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min 1 wk 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>HBP, Purpura, C.H.F. + old Demod. ulcer</u>											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/2/1955</u> to <u>3/16/1982</u> that (I) (we) last saw the deceased alive on <u>3/13/1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen Jones</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/16/12			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Jones, M.D.				22e. ADDRESS 809 Viers Mill Road Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville, Maryland			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR MAR 19 1982		25b. REGISTRAR'S SIGNATURE <u>James Van Nuthen</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 7 4 0 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Richard W Allnutt</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>March 19 1982</i>			2b. HOUR M		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 31 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>75</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montg. Co.</i> MD.					
10. CITY OR TOWN OF DEATH <i>Poolesville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>21134 Westertly Rd.</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>MD. Montg.</i>		13c. CITY OR TOWN <i>Poolesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>21134 Westertly Rd.</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph N Allnutt</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lucie W. Williams</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>217 36 6742</i>		17. INFORMANT ADDRESS <i>Mrs. Allnutt Poolesville Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>atherosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i> <i>5 years +</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <i>Cancer of urinary bladder 2 chronic obstructive Pulmonary disease</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <i>Dec 19 81</i> to <i>March 19 82</i> , that (I) (we) lost saw the deceased alive on <i>March 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Henry V Chase M.D.</i>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Mar. 20, 1982</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Henry V. Chase M.D.</i>						22e. ADDRESS <i>804 Toll House Ave Frederick MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>3/23/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>MURRAY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Beallsville Montg. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>Lucy Helth</i>						ADDRESS <i>Barnwell Rd.</i>		25a. DATE REC'D. BY REGISTRAR <i>MAR 26 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James G. ...</i>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY OTHER AGENCY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST CHRISTIE		MIDDLE CHRISTINE		LAST LYNN ANDERSON		2a. DATE KNOWN OF DEATH MONTH DAY YEAR <input checked="" type="checkbox"/> 3-7-82 19		2b. HOUR M M	
3. SEX female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR DEC 27 1981		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 2 8		IF UNDER 1 YR. HOURS MIN. 2 8		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-7-82 19		7d. HOUR M 10:50A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2351 GLENMONT CIRCLE 20902			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT GANDY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLENE M. ANDERSON				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. N/A				17. INFORMANT CHARLENE M. ANDERSON				17. ADDRESS SAME AS 13 MOTHER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden infant death syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 3-8-82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/10/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAR 12 1982		25b. REGISTRAR'S SIGNATURE Francis J. Collins			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 0 2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		LAST		3 17 82		4 20 AM	
ELLA Wright XXXXXXXXXX Anderson		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		10 5 1892		89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Wash., D. C.		U. S. A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		Rockville Nursing Home		Housewife		---	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		303 Adclare Road			
William Warren		Julia		Blanche		Hanson	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
No		578-46-2355		William E. Anderson		12321 Bluhill Rd.	
				Wheaton		Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cardiothoracic Arrest		Acute CVA			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		2/21, 19 78, to		3-7-82, 19 82, that (I) (last)			
saw the deceased alive on		3/15, 19 82, and that in (my) (last) opinion death occurred on the date and hour and from the causes stated		above, (I) (last) (did not) view the body after death			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Carol L. Bender		M.D.		3/19/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Carol L. Bender		11510 Old Georgetown Rd. Rckvl., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		3/19/82		Congressional Cemetery		Washington, D. C.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			
Warner E. Pumphrey, Inc.		P.O. Box 7428 Sil. Spr., Md.		MAR 22 1982			

25b. REGISTRAR'S SIGNATURE
Charles Jan Weather

STANDARD FORM NO. 64
MAY 1962 EDITION
GSA GEN. REG. NO. 27



1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 7 4 0 3	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Lucille W. Andrews		March 25, 1982		uncertain	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	white	Oct. 9 1895	86	Montgomery	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	13a. USUAL OCCUPATION		
Texas	US	NEVER MARRIED	Home		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION	13b. STREET ADDRESS	13c. CITY OR TOWN		
Bethesda	5101 River Rd.	5101 River Road	Bethesda		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Guinn	Williams	No			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
579-60-7374	Lorane A Wilson	10112 Colebrook Av. Potomac, Md			
18. CAUSE OF DEATH		19. DATE OF OPERATION		20a. AUTOPSY?	
Cardio-vascular disease		4292		YES	
DUE TO, OR AS A CONSEQUENCE OF		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
none		none		none	
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME	
Allen J. O'Neill		March 25, 1982		Allen J. O'Neill MD	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		3/26/82		Cedar Hill Crematory	
23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Suitland, Md.		Joseph Gawler Sons Inc.		MAR 29 1982	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S NAME			
James Van Winkle		James Van Winkle			

Handwritten text, likely bleed-through from the reverse side of the page. The text is illegible due to fading and the circular punch hole.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 0 4

1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George T HOMSON				2a. DATE OF DEATH MONTH DAY YEAR March 9, 1982		2b. HOUR 4:38 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 8, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YES <input type="checkbox"/> NO <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCIENTIST/CHEMIST		12b. KIND OF BUSINESS OR INDUSTRY NATL BUREAU OF STANDARDS	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. INSIDE-CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE A. ARMSTRONG		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET FARIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 267-18-4470	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH	
17a. NAME		17b. ADDRESS		18a. IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION			
17c. NAME		17d. ADDRESS		18b. DUE TO, OR AS A CONSEQUENCE OF (b) 4100			
17e. NAME		17f. ADDRESS		18c. DUE TO, OR AS A CONSEQUENCE OF (c) 4100			
17g. NAME		17h. ADDRESS		18d. DUE TO, OR AS A CONSEQUENCE OF (d) 4100			
17i. NAME		17j. ADDRESS		18e. DUE TO, OR AS A CONSEQUENCE OF (e) 4100			
17k. NAME		17l. ADDRESS		18f. DUE TO, OR AS A CONSEQUENCE OF (f) 4100			
17m. NAME		17n. ADDRESS		18g. DUE TO, OR AS A CONSEQUENCE OF (g) 4100			
17o. NAME		17p. ADDRESS		18h. DUE TO, OR AS A CONSEQUENCE OF (h) 4100			
17q. NAME		17r. ADDRESS		18i. DUE TO, OR AS A CONSEQUENCE OF (i) 4100			
17s. NAME		17t. ADDRESS		18j. DUE TO, OR AS A CONSEQUENCE OF (j) 4100			
17u. NAME		17v. ADDRESS		18k. DUE TO, OR AS A CONSEQUENCE OF (k) 4100			
17w. NAME		17x. ADDRESS		18l. DUE TO, OR AS A CONSEQUENCE OF (l) 4100			
17y. NAME		17z. ADDRESS		18m. DUE TO, OR AS A CONSEQUENCE OF (m) 4100			
17aa. NAME		17ab. ADDRESS		18n. DUE TO, OR AS A CONSEQUENCE OF (n) 4100			
17ac. NAME		17ad. ADDRESS		18o. DUE TO, OR AS A CONSEQUENCE OF (o) 4100			
17ae. NAME		17af. ADDRESS		18p. DUE TO, OR AS A CONSEQUENCE OF (p) 4100			
17ag. NAME		17ah. ADDRESS		18q. DUE TO, OR AS A CONSEQUENCE OF (q) 4100			
17ai. NAME		17aj. ADDRESS		18r. DUE TO, OR AS A CONSEQUENCE OF (r) 4100			
17ak. NAME		17al. ADDRESS		18s. DUE TO, OR AS A CONSEQUENCE OF (s) 4100			
17am. NAME		17an. ADDRESS		18t. DUE TO, OR AS A CONSEQUENCE OF (t) 4100			
17ao. NAME		17ap. ADDRESS		18u. DUE TO, OR AS A CONSEQUENCE OF (u) 4100			
17aq. NAME		17ar. ADDRESS		18v. DUE TO, OR AS A CONSEQUENCE OF (v) 4100			
17as. NAME		17at. ADDRESS		18w. DUE TO, OR AS A CONSEQUENCE OF (w) 4100			
17au. NAME		17av. ADDRESS		18x. DUE TO, OR AS A CONSEQUENCE OF (x) 4100			
17aw. NAME		17ax. ADDRESS		18y. DUE TO, OR AS A CONSEQUENCE OF (y) 4100			
17ay. NAME		17az. ADDRESS		18z. DUE TO, OR AS A CONSEQUENCE OF (z) 4100			
17ba. NAME		17bb. ADDRESS		18aa. DUE TO, OR AS A CONSEQUENCE OF (aa) 4100			
17bc. NAME		17bd. ADDRESS		18ab. DUE TO, OR AS A CONSEQUENCE OF (ab) 4100			
17be. NAME		17bf. ADDRESS		18ac. DUE TO, OR AS A CONSEQUENCE OF (ac) 4100			
17bg. NAME		17bh. ADDRESS		18ad. DUE TO, OR AS A CONSEQUENCE OF (ad) 4100			
17bi. NAME		17bj. ADDRESS		18ae. DUE TO, OR AS A CONSEQUENCE OF (ae) 4100			
17bk. NAME		17bl. ADDRESS		18af. DUE TO, OR AS A CONSEQUENCE OF (af) 4100			
17bm. NAME		17bn. ADDRESS		18ag. DUE TO, OR AS A CONSEQUENCE OF (ag) 4100			
17bo. NAME		17bp. ADDRESS		18ah. DUE TO, OR AS A CONSEQUENCE OF (ah) 4100			
17br. NAME		17bs. ADDRESS		18ai. DUE TO, OR AS A CONSEQUENCE OF (ai) 4100			
17bt. NAME		17bu. ADDRESS		18aj. DUE TO, OR AS A CONSEQUENCE OF (aj) 4100			
17bv. NAME		17bv. ADDRESS		18ak. DUE TO, OR AS A CONSEQUENCE OF (ak) 4100			
17bw. NAME		17bw. ADDRESS		18al. DUE TO, OR AS A CONSEQUENCE OF (al) 4100			
17bx. NAME		17bx. ADDRESS		18am. DUE TO, OR AS A CONSEQUENCE OF (am) 4100			
17by. NAME		17by. ADDRESS		18an. DUE TO, OR AS A CONSEQUENCE OF (an) 4100			
17bz. NAME		17bz. ADDRESS		18ao. DUE TO, OR AS A CONSEQUENCE OF (ao) 4100			
17ca. NAME		17ca. ADDRESS		18ap. DUE TO, OR AS A CONSEQUENCE OF (ap) 4100			
17cb. NAME		17cb. ADDRESS		18aq. DUE TO, OR AS A CONSEQUENCE OF (aq) 4100			
17cc. NAME		17cc. ADDRESS		18ar. DUE TO, OR AS A CONSEQUENCE OF (ar) 4100			
17cd. NAME		17cd. ADDRESS		18as. DUE TO, OR AS A CONSEQUENCE OF (as) 4100			
17ce. NAME		17ce. ADDRESS		18at. DUE TO, OR AS A CONSEQUENCE OF (at) 4100			
17cf. NAME		17cf. ADDRESS		18au. DUE TO, OR AS A CONSEQUENCE OF (au) 4100			
17cg. NAME		17cg. ADDRESS		18av. DUE TO, OR AS A CONSEQUENCE OF (av) 4100			
17ch. NAME		17ch. ADDRESS		18aw. DUE TO, OR AS A CONSEQUENCE OF (aw) 4100			
17ci. NAME		17ci. ADDRESS		18ax. DUE TO, OR AS A CONSEQUENCE OF (ax) 4100			
17cj. NAME		17cj. ADDRESS		18ay. DUE TO, OR AS A CONSEQUENCE OF (ay) 4100			
17ck. NAME		17ck. ADDRESS		18az. DUE TO, OR AS A CONSEQUENCE OF (az) 4100			
17cl. NAME		17cl. ADDRESS		18ba. DUE TO, OR AS A CONSEQUENCE OF (ba) 4100			
17cm. NAME		17cm. ADDRESS		18bb. DUE TO, OR AS A CONSEQUENCE OF (bb) 4100			
17cn. NAME		17cn. ADDRESS		18bc. DUE TO, OR AS A CONSEQUENCE OF (bc) 4100			
17co. NAME		17co. ADDRESS		18bd. DUE TO, OR AS A CONSEQUENCE OF (bd) 4100			
17cp. NAME		17cp. ADDRESS		18be. DUE TO, OR AS A CONSEQUENCE OF (be) 4100			
17cq. NAME		17cq. ADDRESS		18bf. DUE TO, OR AS A CONSEQUENCE OF (bf) 4100			
17cr. NAME		17cr. ADDRESS		18bg. DUE TO, OR AS A CONSEQUENCE OF (bg) 4100			
17cs. NAME		17cs. ADDRESS		18bh. DUE TO, OR AS A CONSEQUENCE OF (bh) 4100			
17ct. NAME		17ct. ADDRESS		18bi. DUE TO, OR AS A CONSEQUENCE OF (bi) 4100			
17cu. NAME		17cu. ADDRESS		18bj. DUE TO, OR AS A CONSEQUENCE OF (bj) 4100			
17cv. NAME		17cv. ADDRESS		18bk. DUE TO, OR AS A CONSEQUENCE OF (bk) 4100			
17cw. NAME		17cw. ADDRESS		18bl. DUE TO, OR AS A CONSEQUENCE OF (bl) 4100			
17cx. NAME		17cx. ADDRESS		18bm. DUE TO, OR AS A CONSEQUENCE OF (bm) 4100			
17cy. NAME		17cy. ADDRESS		18bn. DUE TO, OR AS A CONSEQUENCE OF (bn) 4100			
17cz. NAME		17cz. ADDRESS		18bo. DUE TO, OR AS A CONSEQUENCE OF (bo) 4100			
17da. NAME		17da. ADDRESS		18bp. DUE TO, OR AS A CONSEQUENCE OF (bp) 4100			
17db. NAME		17db. ADDRESS		18bq. DUE TO, OR AS A CONSEQUENCE OF (bq) 4100			
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17dd. NAME		17dd. ADDRESS		18bs. DUE TO, OR AS A CONSEQUENCE OF (bs) 4100			
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17df. NAME		17df. ADDRESS		18bu. DUE TO, OR AS A CONSEQUENCE OF (bu) 4100			
17dg. NAME		17dg. ADDRESS		18bv. DUE TO, OR AS A CONSEQUENCE OF (bv) 4100			
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17di. NAME		17di. ADDRESS		18bx. DUE TO, OR AS A CONSEQUENCE OF (bx) 4100			
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17dn. NAME		17dn. ADDRESS		18cc. DUE TO, OR AS A CONSEQUENCE OF (cc) 4100			
17do. NAME		17do. ADDRESS		18cd. DUE TO, OR AS A CONSEQUENCE OF (cd) 4100			
17dp. NAME		17dp. ADDRESS		18ce. DUE TO, OR AS A CONSEQUENCE OF (ce) 4100			
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17dw. NAME		17dw. ADDRESS		18cl. DUE TO, OR AS A CONSEQUENCE OF (cl) 4100			
17dx. NAME		17dx. ADDRESS		18cm. DUE TO, OR AS A CONSEQUENCE OF (cm) 4100			
17dy. NAME		17dy. ADDRESS		18cn. DUE TO, OR AS A CONSEQUENCE OF (cn) 4100			
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17eb. NAME		17eb. ADDRESS		18cq. DUE TO, OR AS A CONSEQUENCE OF (cq) 4100			
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17ei. NAME		17ei. ADDRESS		18da. DUE TO, OR AS A CONSEQUENCE OF (da) 4100			
17ei. NAME		17ei. ADDRESS		18db. DUE TO, OR AS A CONSEQUENCE OF (db) 4100			
17ej. NAME		17ej. ADDRESS		18dc. DUE TO, OR AS A CONSEQUENCE OF (dc) 4100			
17ej. NAME		17ej. ADDRESS		18dd. DUE TO, OR AS A CONSEQUENCE OF (dd) 4100			
17ek. NAME		17ek. ADDRESS		18de. DUE TO, OR AS A CONSEQUENCE OF (de) 4100			
17ek. NAME		17ek. ADDRESS		18df. DUE TO, OR AS A CONSEQUENCE OF (df) 4100			
17el. NAME		17el. ADDRESS		18dg. DUE TO, OR AS A CONSEQUENCE OF (dg) 4100			
17el. NAME		17el. ADDRESS		18dh. DUE TO, OR AS A CONSEQUENCE OF (dh) 4100			
17em. NAME		17em. ADDRESS		18di. DUE TO, OR AS A CONSEQUENCE OF (di) 4100			
17em. NAME		17em. ADDRESS		18dj. DUE TO, OR AS A CONSEQUENCE OF (dj) 4100			
17en. NAME		17en. ADDRESS		18dk. DUE TO, OR AS A CONSEQUENCE OF (dk) 4100			
17en. NAME		17en. ADDRESS		18dl. DUE TO, OR AS A CONSEQUENCE OF (dl) 4100			
17eo. NAME		17eo. ADDRESS		18dm. DUE TO, OR AS A CONSEQUENCE OF (dm) 4100			
17eo. NAME		17eo. ADDRESS		18dn. DUE TO, OR AS A CONSEQUENCE OF (dn) 4100			
17ep. NAME		17ep. ADDRESS		18do. DUE TO, OR AS A CONSEQUENCE OF (do) 4100			
17ep. NAME		17ep. ADDRESS		18dp. DUE TO, OR AS A CONSEQUENCE OF (dp) 4100			
17eq. NAME		17eq. ADDRESS		18dq. DUE TO, OR AS A CONSEQUENCE OF (dq) 4100			
17eq. NAME		17eq. ADDRESS		18dr. DUE TO, OR AS A CONSEQUENCE OF (dr) 4100			
17er. NAME		17er. ADDRESS		18ds. DUE TO, OR AS A CONSEQUENCE OF (ds) 4100			
17er. NAME		17er. ADDRESS		18dt. DUE TO, OR AS A CONSEQUENCE OF (dt) 4100			
17es. NAME		17es. ADDRESS		18du. DUE TO, OR AS A CONSEQUENCE OF (du) 4100			
17es. NAME		17es. ADDRESS		18dv. DUE TO, OR AS A CONSEQUENCE OF (dv) 4100			
17et. NAME		17et. ADDRESS		18dw. DUE TO, OR AS A CONSEQUENCE OF (dw) 4100			
17et. NAME		17et. ADDRESS		18dx. DUE TO, OR AS A CONSEQUENCE OF (dx) 4100			
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17eu. NAME		17eu. ADDRESS		18dz. DUE TO, OR AS A CONSEQUENCE OF (dz) 4100			
17ev. NAME		17ev. ADDRESS		18ea. DUE TO, OR AS A CONSEQUENCE OF (ea) 4100			
17ev. NAME		17ev. ADDRESS		18eb. DUE TO, OR AS A CONSEQUENCE OF (eb) 4100			
17ew. NAME		17ew. ADDRESS		18ec. DUE TO, OR AS A CONSEQUENCE OF (ec) 4100			
17ew. NAME		17ew. ADDRESS		18ed. DUE TO, OR AS A CONSEQUENCE OF (ed) 4100			
17ex. NAME		17ex. ADDRESS		18ee. DUE TO, OR AS A CONSEQUENCE OF (ee) 4100			
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17ey. NAME		17ey. ADDRESS		18eg. DUE TO, OR AS A CONSEQUENCE OF (eg) 4100			
17ey. NAME		17ey. ADDRESS		18eh. DUE TO, OR AS A CONSEQUENCE OF (eh) 4100			
17ez. NAME		17ez. ADDRESS		18ei. DUE TO, OR AS A CONSEQUENCE OF (ei) 4100			
17ez. NAME		17ez. ADDRESS		18ej. DUE TO, OR AS A CONSEQUENCE OF (ej) 4100			
17fa. NAME		17fa. ADDRESS		18ek. DUE TO, OR AS A CONSEQUENCE OF (ek) 4100			
17fa. NAME		17fa. ADDRESS		18el. DUE TO, OR AS A CONSEQUENCE OF (el) 4100			
17fb. NAME		17fb. ADDRESS		18em. DUE TO, OR AS A CONSEQUENCE OF (em) 4100</			

BP

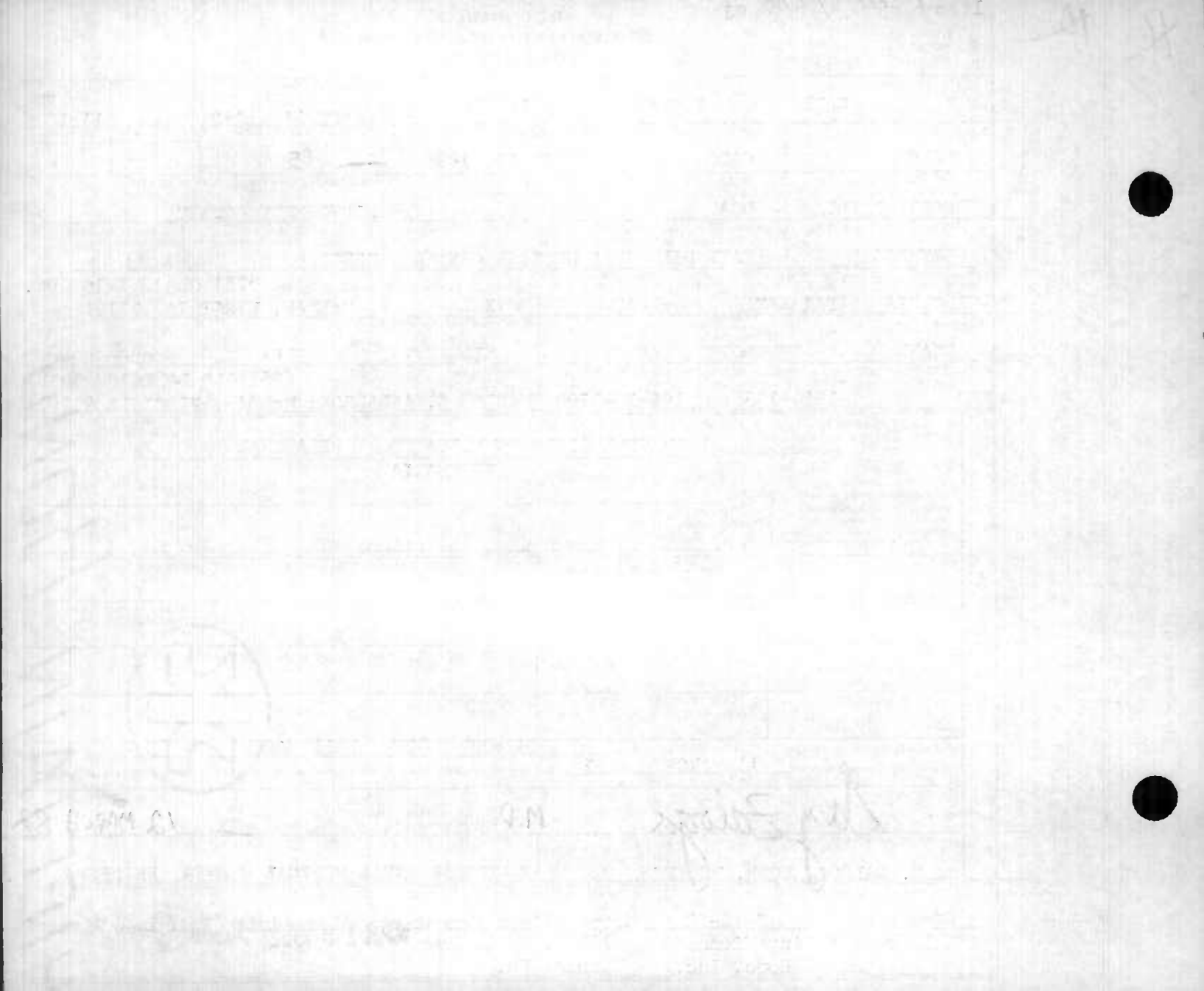
DHMH-16 SOM 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
CARL INGMAN ASLAKSON					MARCH 11, 1982				
3 SEX					4. RACE				
MALE					CAUC				
5 DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
APRIL 23, 1896					86 85 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
NORTH DAKOTA					USA				
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH				
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				
BETHESDA					NATIONAL NAVAL MEDICAL CENTER				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
RETIRED					NOAA				
13a. STREET ADDRESS					13b. CITY OR TOWN				
6251 OLD DOMINION DR.					McLEAN, VIRGINIA 22101				
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FRANK THEODORE ASLAKSON					MINNESOTA ELLA INGMUNDSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
YES					1914-1955 194-30-3700				
17. INFORMANT					ADDRESS				
MARIAN C. ASLAKSON: McLEAN, VIRGINIA 22101					6251 OLD DOMINION DRIVE				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY									
IMMEDIATE CAUSE (a) DERMATOMYOSITIS COMPLICATED BY BILATERAL PNEUMONIA									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?									
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY									
HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION									
STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 02 FEBRUARY 19 82 to 11 MARCH 19 82, that (I) (we) lost saw the deceased alive on 11 MARCH 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
DEGREE									
M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22c. DATE SIGNED									
12 MARCH 82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
G. ZALOGA LCDR, MC USN									
22e. ADDRESS									
NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
Cremation									
23b. DATE									
3-15-82									
23c. NAME OF CEMETERY OR CREMATORY									
Metropolitan Crematory Alexandria Fairfax Virginia									
23d. LOCATION									
CITY OR TOWN COUNTY STATE									
171 W. Maple Ave Vienna, Va.									
24 FUNERAL DIRECTOR									
NAME Money & King Vienna									
ADDRESS									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 0 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Faye Elizabeth Aud						2a. DATE OF DEATH MONTH DAY YEAR March 13, 1982			2b. HOUR 9:00 A M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 9, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Kentucky		13b. COUNTY Hancock		13c. CITY OR TOWN Hawesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Route 2		42348	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Brown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda nmn Gloyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS 403-38-5380		Mr. William E. Aud (husband) same as patient					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 Brain edema probably due to metastatic breast cancer DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia, bilateral, lower lobes DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 19, 1982, to March 13, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 13, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If not, indicate <input checked="" type="checkbox"/> the body after death.											
22b. SIGNATURE Eddie Reed, MD				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eddie Reed, MD				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md., 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-17-1982		23c. NAME OF CEMETERY OR CREMATORY Blackford Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hawesville, Hancock, Ky					
24. FUNERAL DIRECTOR W. W. Chambers Co., Inc 8655 Georgia Ave Silver Spring, Md., 20910				25a. DATE REC'D. BY REGISTRAR MAR 16 1982		25b. REGISTRAR'S SIGNATURE Rene J. [Signature]					

BP

January

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January 1-1-19

January 1-1-19

Item #1 Film G565 3/23/82 rc

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Stallard		FIRST Barnette		MIDDLE Barnett		2a. DATE OF DEATH MONTH DAY YEAR MARCH 4 82		2b. HOUR 8:55PM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH DAY MONTH YEAR 15 NOV. 1919		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Labor		12b. KIND OF BUSINESS OR INDUSTRY Landscape	
13a. STATE MD		13b. COUNTY MONTG		13c. CITY BICKERSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. STREET ADDRESS Box 200 RT. # 28	
14 FATHER'S NAME FIRST MIDDLE LAST Liberty Jackson Barnette		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Lane							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 230-18-3589		17. INFORMANT ADDRESS Grace Barnette Same as #13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC OBSTRUCTIVE PULMONARY DISEASE.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from FEB 27 , 19 82 , to MARCH 4 , 19 82 , that (I) (we) last saw the deceased alive on MARCH 4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugene P. Flannery, MD				DEGREE MD				22c. DATE SIGNED 5 MAR - 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, MD				22e. ADDRESS 1811 PRINCE PHILIP DR. OLNEY, MD. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Love Gospel		23d. LOCATION CITY OR TOWN COUNTY STATE Lisbon Howard Md.			
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

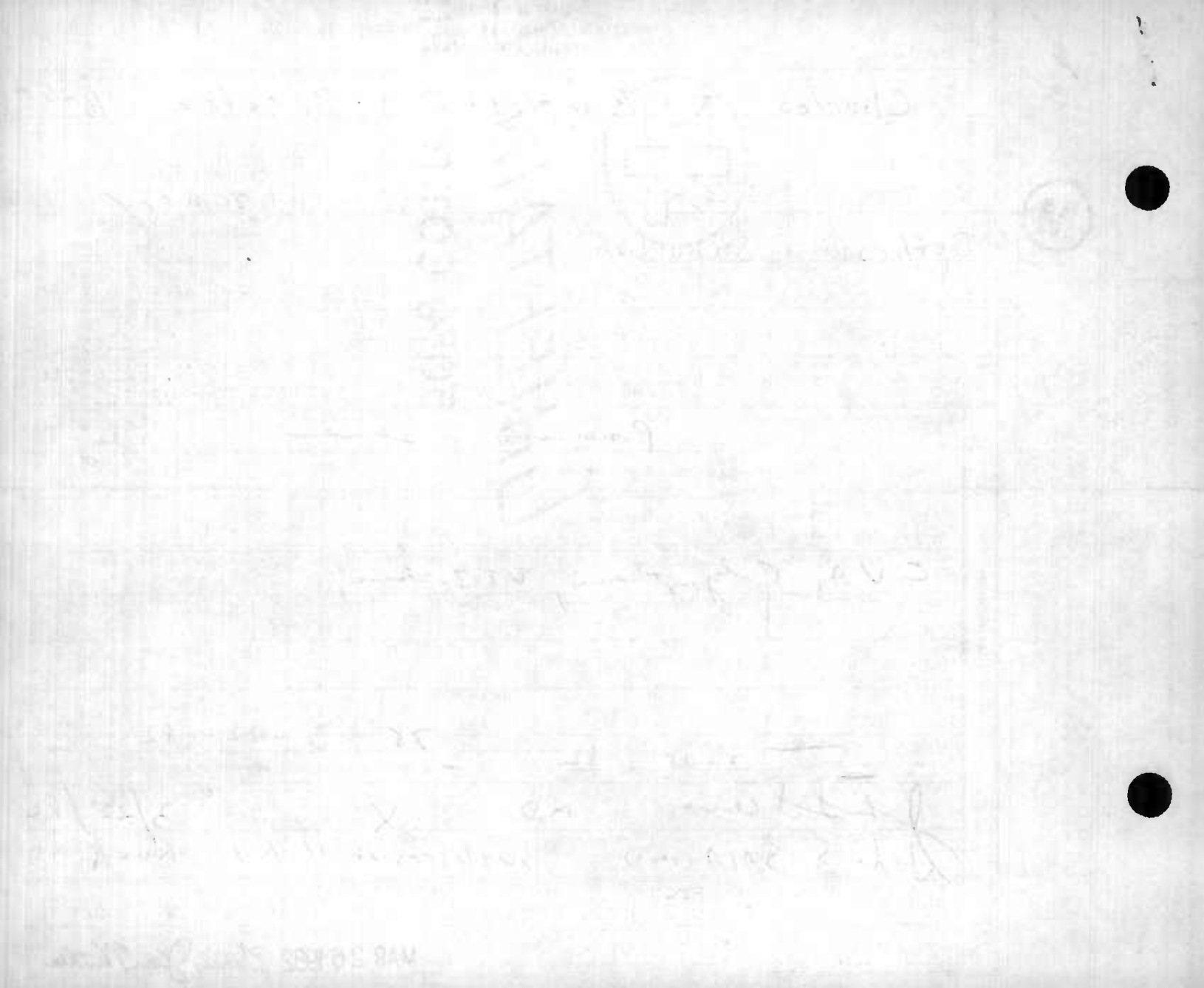
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 0 8			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Charles J. Bartlett								3/22/82					10 25 ^M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))		8. IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		Caucasian		Feb. 18, 1909		73 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
New York		United States				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda		Suburban Hospital		Banker		Banking							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1235 Potomac Valley Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Charles W. Bartlett		Elizabeth Yendley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		113 01 0139		Son		340 W. Edmonston							
				Charles B. Bartlett		Rockville, Md.							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Pneumonia - severe												2 days	
4860 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
CVA, Polycythemia, UTI - chan													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (the hospital) attended the deceased from 78, to 3-22-82, that (1) (the deceased) died on 3-15-82, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If () did not view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
John S. SAIA MD		MD		3/22/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
John S. SAIA MD		809 Viens Mill Rd		Rock MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		March 25, 1982		Mt. Carmel Cemetery		Tenafly, New Jersey							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		MAR 26 1982		Francis Jan Nathan									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 0 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hazel S. Bean			2a. DATE OF DEATH MONTH DAY YEAR March 24, 1982		2b. HOUR 8:48 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY DC Schools	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edwin E. Spear			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva (not available)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-44-2362		17. INFORMANT John P. Spear	
ADDRESS 9838 East Ida Circle Englewood, Colorado					

18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4589 Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) Shock - Hypotension of DUE TO, OR AS A CONSEQUENCE OF (c) Unknown cause		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes minutes
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Renal Abscess and Carcinoma**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 3/1 19 82 to 3/24 19 82 , that (I) (we) last saw the deceased alive on 3/24 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) did not view the body after death.			

27a. SIGNATURE Stephen J. Newman	DEGREE MD	27c. DATE SIGNED 3/25/82
27b. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman, M.D.		27d. ADDRESS 11500 Old Georgetown Road Rockville, Maryland 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 27, 1982	23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland			25a. DATE REC'D. BY REGISTRAR MAR 31 1982
			25b. REGISTRAR'S SIGNATURE Frances Jan Nathan

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

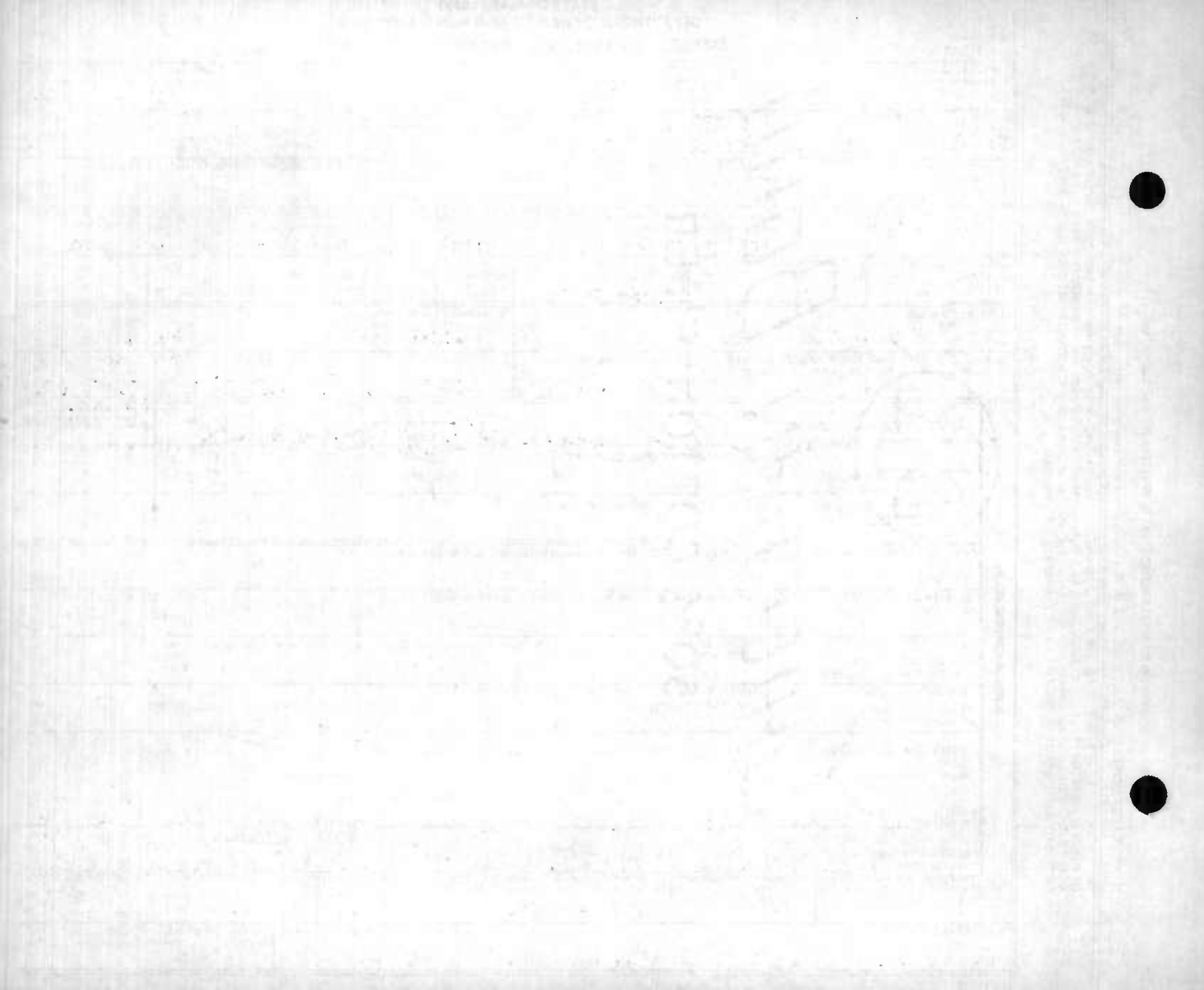
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR 115 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 0 7 4 1 0		
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELIZABETH SOUTHALL BENISH										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 3/6/82 19		2b. HOUR 12:00 pm
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR		2e. HOUR		
Female	White	3/26/22	58 YRS.			3/6/82 19		12:00		pm		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
PETERSBURG, VA		USA				MONTGOMERY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Washington Adventist Hospital				HOUSEWIFE		OWN HOME				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
VA		FAIRFAX		Great Falls		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9715 Georgetown Pike				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
HENRY CALVIN SOUTHALL				LINDA VAUGHN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
NO				230-18-6397		CHERYL CROOK (DAUGHTER)		9715 OLD GEORGETOWN PIKE, FALLS CHURCH, VA				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED						
RICHARD L. WHELTON		Deputy Medical Examiner				3-6-82						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										
RICHARD L. WHELTON		7700 Baltimore Ave. College Park, MD 20740										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
BURIAL		3/9/82		NATIONAL MEM. PARK		FALLS CHURCH		VIRGINIA				
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
J. BERKLEY GREEN, 721 ELDEN ST., HERNDON, VA				MAR 10 1982								



DHMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2e. DATE KNOWN OF ESTI- DEATH MATED		MONTH		DAY		YEAR		2b. HOUR	
MICHAEL		S.		BENNETT				3		15		19		82		2:10 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		Caucas.		Mar. 15, 1954		28				3		15		19		82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Virginia		United States				MONTGOMERY											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN MUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
BETHESDA		SUBURBAN HOSPITAL		Carpenter		Home Bldg.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS									
Maryland		Montgomery		Germantown				13207 Dairymaid Drive									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Archie W. Bennett		Frances Bailey															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		1973-1974		214 60 1681		Wife		13207 Dairymaid Dr.									
						Jane A. Bennett		Germantown, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Abdomen</u> 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>Self-Inflicted</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 6:55 P.M. 2 21 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Shot-Seven approx abdomen 12 gauge shot gun.</u>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>13207 Dairymaid Dr. Gaithersburg Mont. Md.</u>													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion															
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>John G. Ball</u>		TITLE (SPECIFY) M.D. <u>Deputy</u>		MEDICAL EXAMINER		DATE SIGNED <u>March 15, 1982</u>											
EXAMINER'S NAME (TYPE OR PRINT)		John G. Ball, M.D.		7936 Old Georgetown Rd. Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria											
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		25a. DATE REC'D. BY REGISTRAR MAR 19 1982		25b. REGISTRAR'S SIGNATURE <u>John G. Ball</u>													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 1 2			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alice M. Berry</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>March 29, 1982</i>		2b. HOUR <i>0310 P.M.</i>	
3. SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>April 22, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>60</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING TIME) <i>Cafeteria Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>School</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Prince Geo.</i>		13c. CITY OR TOWN <i>Chillum</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jacob France</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Agnes Flahanghnam</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			
16b. SOCIAL SECURITY NO. <i>579 18 7728</i>		17. INFORMANT ADDRESS <i>Davis H. Berry Same as #13 (Husband)</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> 3949 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Rheumatic mitral disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>45 yrs.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Bronchial Asthma</i>							
19a. DATE OF OPERATION <i>Mar 29, 1982</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 29, 1982</i> to <i>Mar 29, 1982</i> , that (I) (we) lost saw the deceased alive on <i>Mar 29, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur S. Bresler</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>Mar 29, 1982</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur S. Bresler, M.D.</i>				22e. ADDRESS <i>10881 Lockwood Drive Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>4/1/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood P. Co. Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>Francis Gasch's Sons Funeral Home, P.A.</i>				25a. MAR 31 1982			
ADDRESS <i>Hyattsville, Maryland</i>				25b. SIGNATURE			

BP

1993-1994

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1991-1992

Notes

DATE: 11/11/1968

9577 RI 075

don't.

[1089] Jackson, Silver Spring, Md., 1989

• • • • •

Figure 1

... and there's one thing I know...

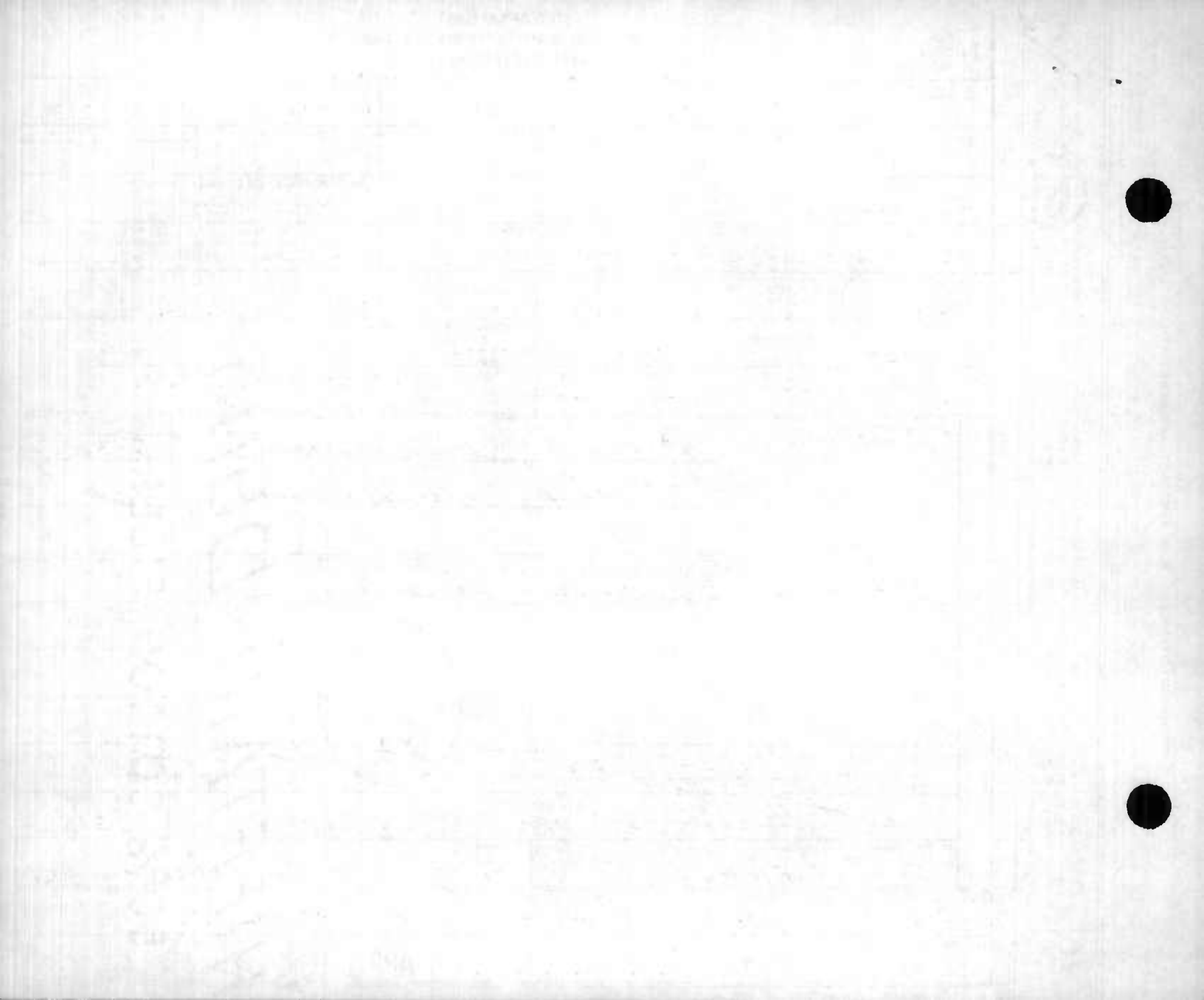
Keywords: *child abuse; child neglect; child maltreatment*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR		REG. NO. 82 07413								
1. DECEASED NAME (TYPE OR PRINT) Janie N. Biggs					2a. DATE OF DEATH MONTH DAY YEAR March 29 1982		2b. HOUR P 11:30 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 3, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U S Gov't		12b. KIND OF BUSINESS OR INDUSTRY Secretary		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.					13b. CITY OR TOWN Wash. D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1515 32nd St. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Sylvester Biggs					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Napier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None					16b. SOCIAL SECURITY NO. 579 18 8316		17. INFORMANT 2917 Shanandale Dr. S.S. Md. Robert Fetner (Nephew)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> Yrs. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Alzheimer's Syndrome, Hypertension</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 19 82, to 3/29 19 82, that (I) (we) last saw the deceased alive on 3/29 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>[Signature]</i> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 3/30/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. T. BENACK MD						22e. ADDRESS 4115 Colie Dr. Wheaton, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/3/82		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 N.H. Ave. S.S. Md.						25a. DATE REC'D. BY REGISTRAR APR 1 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

JOHN L. BLIVEN 1 4

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN		MIDDLE L.		LAST Bliven		2b. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 3 13 82		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 13 82		2d. HOUR 4:37 a M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb. 2 1948 34 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 13 82		7d. HOUR 4:37 a M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wall Paper Interior		12b. KIND OF BUSINESS OR INDUSTRY HANKER							
13a. STATE Md.		13b. COUNTY P. Geo.		13c. CITY OR TOWN Lanham.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6423 Brightlea. Dr.					
14. FATHER'S NAME Charles W. Bliven				15. MOTHER'S MAIDEN NAME Marjorie B. Brew.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN)		16b. SOCIAL SECURITY NO. 220-50-7335		17. INFORMANT Harold Hirst.		17. ADDRESS (13 e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:02x 3-13- 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Passenger in auto/fixed object collision.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Balto. & Albany Ave., Takoma Park, Mont. Md.					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 3-14-82					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 19, 1982				23c. NAME OF CEMETERY OR CREMATORY Cheney Cemetery, Cheney, Neb.				23d. LOCATION CITY OR TOWN COUNTY STATE Cheney, Neb.	
24. FUNERAL DIRECTOR 				25a. DATE REC'D. BY REGISTRAR MAR 17 1982				25b. REGISTRAR'S SIGNATURE 					
25c. ADDRESS 254 Carroll St. N. W. D. C.													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

Bivon

FOR 2000

Washington, D. C. 20540

Mail Paper Interior
4423 Washington, D.C.

Mr. P. Geo. Lathrop

Charles W. Bivon

Yes. 250-26-7332 Harold Bivon. (13 e)

254 Carroll St. N. W. D. C.
Tolson Funeral Home.
Mar. 19, 1982 Cheney Cemetery, Cheney, Neb.

Bivon

25

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 2 0 7 4 1 5	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) Howard Bloom										2b. DATE KNOWN OF DEATH 3-9-1982	
3. SEX MALE										2c. DATE PRONOUNCED DEAD March 9 1982	
4. RACE WHITE										2d. HOUR 10:20 A.M.	
5. DATE OF BIRTH NOV. 20, 1929										2e. DATE PRONOUNCED DEAD March 9 1982	
6. AGE (IN YEARS) 52 YRS.										2f. HOUR 10:20 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK										2g. DATE PRONOUNCED DEAD March 9 1982	
7b. CITIZEN OF WHAT COUNTRY? U. S. A.										2h. DATE PRONOUNCED DEAD March 9 1982	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2i. DATE PRONOUNCED DEAD March 9 1982	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery										2j. DATE PRONOUNCED DEAD March 9 1982	
10. CITY OR TOWN OF DEATH Rockville										2k. DATE PRONOUNCED DEAD March 9 1982	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp										2l. DATE PRONOUNCED DEAD March 9 1982	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INSURANCE										2m. DATE PRONOUNCED DEAD March 9 1982	
12b. KIND OF BUSINESS SELF EMPLOYED										2n. DATE PRONOUNCED DEAD March 9 1982	
13a. STATE Maryland										2o. DATE PRONOUNCED DEAD March 9 1982	
13b. COUNTY Montgomery										2p. DATE PRONOUNCED DEAD March 9 1982	
13c. CITY OR TOWN GERMANTOWN										2q. DATE PRONOUNCED DEAD March 9 1982	
13d. INSIDE CITY LIMITS? YES										2r. DATE PRONOUNCED DEAD March 9 1982	
13e. STREET ADDRESS 20108 Lavender Place										2s. DATE PRONOUNCED DEAD March 9 1982	
14. FATHER'S NAME JEROME										2t. DATE PRONOUNCED DEAD March 9 1982	
15. MOTHER'S MAIDEN NAME LEAH KRESSEL										2u. DATE PRONOUNCED DEAD March 9 1982	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES										2v. DATE PRONOUNCED DEAD March 9 1982	
16b. SOCIAL SECURITY NO. KOREAN 092-20-9092										2w. DATE PRONOUNCED DEAD March 9 1982	
17. INFORMANT SLAVA M. BLOOM, 20108 LAVENDER PLACE, GERMANTOWN, MARYLAND										2x. DATE PRONOUNCED DEAD March 9 1982	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot. Wound. of Neck & Chest. 95552 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Self. Inflicted. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
19c. DATE OF OPERATION										19d. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY 9:30 AM 3-9-1982	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot Self in neck. 22 cal. R. f/2.										21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home.										21f. LOCATION 20108 Lavender Pl. Germantown Mont. Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b. DATE PRONOUNCED DEAD March 9 1982	
ACTUAL SIGNATURE John G. Ball										TITLE (SPECIFY) Deputy	
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL, M. D.										MEDICAL EXAMINER 7936 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 3/15/1982	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY										23d. LOCATION ARLINGTON, ARLINGTON, VA.	
24. FUNERAL DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME										25. DATE REC'D. BY REGISTRAR MAR 11 1982	
26. ADDRESS 232 CARROLL STREET, N. W., WASHINGTON, D. C.										27. REGISTRAR'S SIGNATURE Frank J. [Signature]	

0301 BP
DHMH - 17
(VR A15 AE (5))
15M 2/80

2025 2-7
March 1 2025

Montgomery

Rockville - 2nd Ave. Adventist Hosp.

Call shift Monday, March 2nd
2nd, In Hospital.

Apr 3 82 2nd shift in week, 23rd 1974
2nd shift in week, 23rd 1974
X X X

2nd shift in week, 23rd 1974
2nd shift in week, 23rd 1974
X X X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			REG. NO. 8207416										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
ESTHER W BOSS			March		3		1982		7		30/4 M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		7 MONTH DAY YEAR		72 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.		U.S.A.				Montgomery MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital				Homemaker							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Md.			Mont		Silver Spring		YES		306 Windsor St.				
14. FATHER'S NAME (FIRST MIDDLE LAST)			15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)										
Charles Whitney													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No			214-70-0305		Mr. Harold Boss		Silver Spring, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
5715 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u>										1 year			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute cholecystitis</u>										3 years			
										1 mo			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16c													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
Jan 31, 1982		Acute cholecystitis				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 30, 1982</u> to <u>March 3, 1982</u> , that we (we) last saw the deceased alive on <u>March 3, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DEGREE						22c. DATE SIGNED							
Raymond Bradshaw, MD						March 13, 1982							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Raymond Bradshaw, MD						345 University Blvd., W. Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Removal		3/3/82											
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Anatomy Board						MAR 8 1982		[Signature]					
ADDRESS													
Balto., Md.													

Wanda Weiss

Washington, D.C. U.S.A.

Hoschek

Silver Spring, Md.

Charles Whitney

100-75-0005 Mr. Harold Brown Silver Spring, Md.

Received 5/2/72

Belmont, D.C.

Anthony Board

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8207417			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen B. Bower					2a. DATE OF DEATH MONTH DAY YEAR Mar. 6 82				2b. HOUR 12 ⁵ AM				
3. SEX FE.		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 4 92		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 72 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peoria		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk-Nat'l. Geographic		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 16311 Old Orchard Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST Francis Marion Bassett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ina McElroy								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT Laurence R. Bower (Son)		ADDRESS Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease 59r - } DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk -			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 19 44 to 3-6 1982, that (I) (we) last saw the deceased alive on 2/6 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Wyrta Post Baker MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-6-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WYRTA POST BAKER MD						22e. ADDRESS 4701 Willard Ave - Chevy Chase Md. 20815							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3-8-1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.						
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc. Mt. Rainier, Md.						25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]					

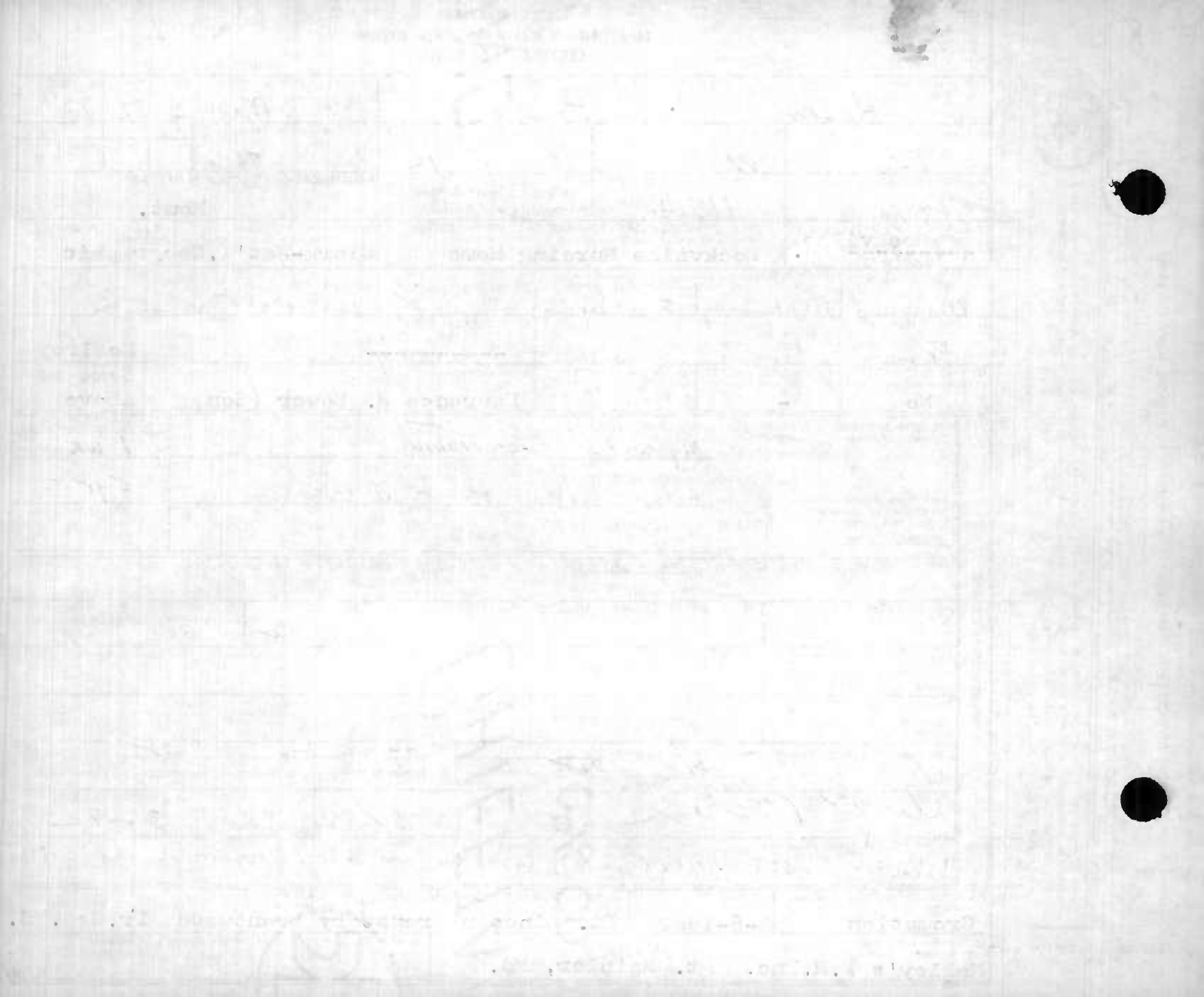
MEDICAL CERTIFICATION

29

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BP

1403



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 3 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. 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Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) JOHN W BOYLE						2a. DATE OF DEATH MONTH DAY YEAR 3-2-82		2b. HOUR 1 P M	
3. SEX Male		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JULY 26, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY FEDERAL GOVT.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13e. STREET ADDRESS 3807 DELANO STREET			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN E. BOYLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLEO V. HOEL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 220-34-9087		17. INFORMANT ADDRESS LILLIAN A. BOYLE SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4 SEPT 19 74 to 2 MAR 82 19 82 that (I) (we) last saw the deceased alive on 2 MAR 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Hubert J. Alpert MD						DEGREE MD		22c. DATE SIGNED 2 MAR 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, M.D.						22e. ADDRESS 8630 FENTON ST SILVER SPRING, MD. 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/5/82		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAR 8 1982			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

HOET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 1 9	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) BABY BOY					2a. DATE OF DEATH MONTH DAY YEAR 3-7-82					2b. HOUR 8:25 M	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-7-82			6. AGE (IN YEARS LAST BIRTHDAY) 0 YRS		IF UNDER 1 YEAR MONTHS DAYS 1 40		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA --		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co. MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENSINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4420 PULLER DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST Mitchell F Brecher					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sandra Lee Levinson					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
17. INFORMANT ADDRESS 4420 PULLER DRIVE					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7651 DUE TO, OR AS A CONSEQUENCE OF (b) Immaturity DUE TO, OR AS A CONSEQUENCE OF (c) 7651					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3/7/82 , 19____, to 3/10/82 , 19____, that (I) (we) last saw the deceased alive on 3/7/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Alan B. Coleman					DEGREE MD					22c. DATE SIGNED 3/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN B. COLEMAN MD					22e. ADDRESS 11119 Rockville pike, Rockville, Md						
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 3/10/1982		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDENS			23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY, MONTGOMERY, MARYLAND			
24. FUNERAL DIRECTOR DONALD M. STEIN					25a. DATE REC'D. BY REGISTRAR MAR 11 1982			25b. REGISTRAR'S SIGNATURE James G. [Signature]			
232 CARROLL STREET, N. W., WASHINGTON, D.C.											

White

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ADDITION

PRINTED

BOOK

1/10/11

1/10/11

Page 4 may be
 TO HOSPITALS: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death occurs. It should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <i>Lottie BRESMAN</i>					2a. DATE OF DEATH MONTH DAY YEAR HOUR <i>MAR. 31 82 11:40 AM</i>					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 28, 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Germany</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Hebrew Home of Greater Washington</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>					13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Markus Leibel</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Paula Gottlieb</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) -----					16b. SOCIAL SECURITY NO. <i>577-26-8491</i>		17. INFORMANT ADDRESS <i>Hermine Zimmer; Sister; 6121 Montrose Rd; Md. Rockville,</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bilateral Pneumonitis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (this hospital) attended the deceased from <i>9/16</i> , 19 <i>80</i> , to <i>3/31</i> , 19 <i>82</i> , that (we) lost <i>saw</i> the deceased alive on <i>3/31</i> , 19 <i>82</i> , and that in (my) last opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <i>R. H. SHAH</i>					DEGREE <i>MD</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>3/31/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. H. SHAH.</i>					22e. ADDRESS <i>6121 Montrose Rd. Rockville</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>April 2, 82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Elesavetgrad Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>				
24. FUNERAL DIRECTOR <i>1170 Rockville Pike; Rockville, DANZANSKY-GOLDBERG MEMORIAL CHAPLES; Maryland</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It shall may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

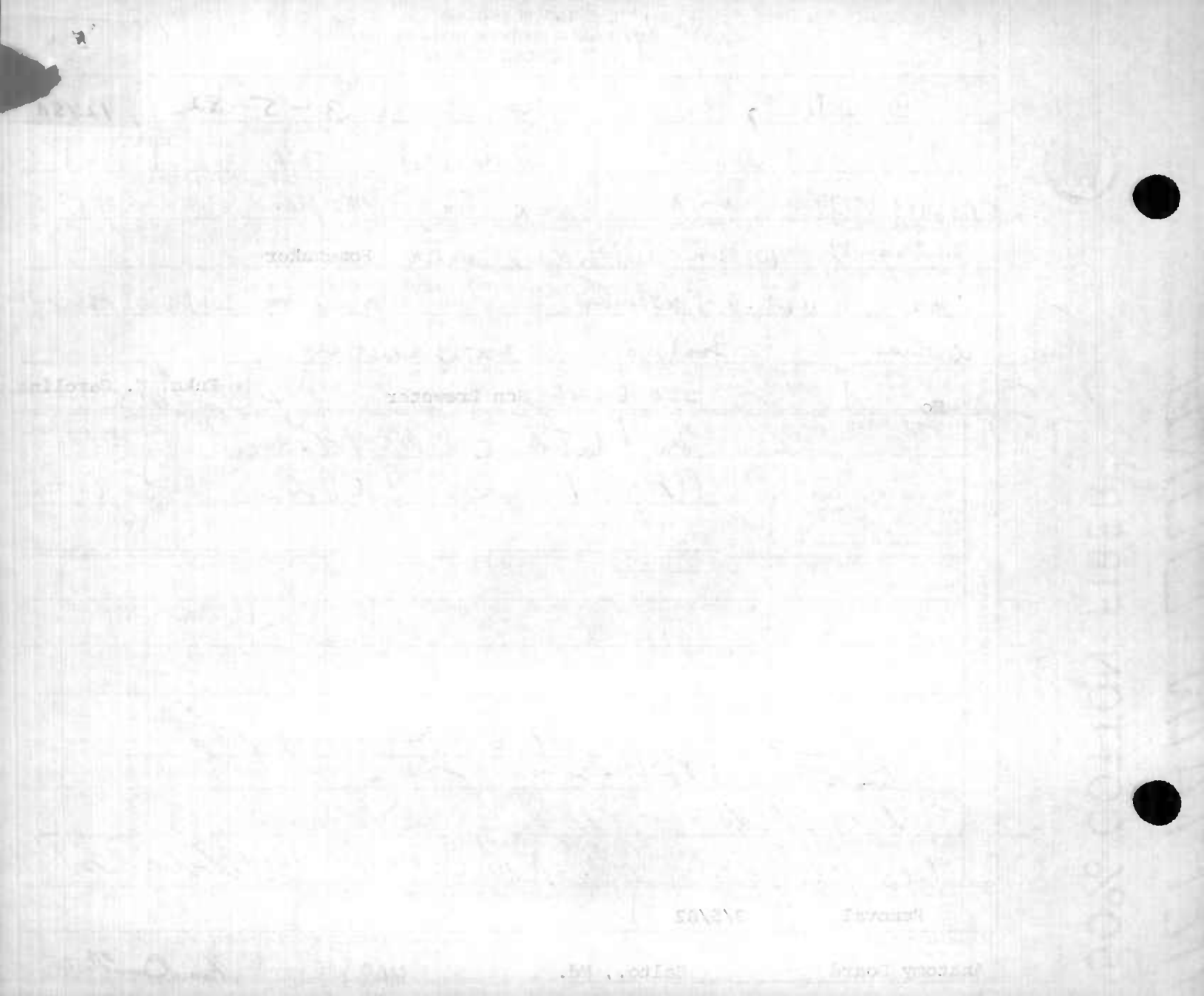
FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 2 1

REG. NO.

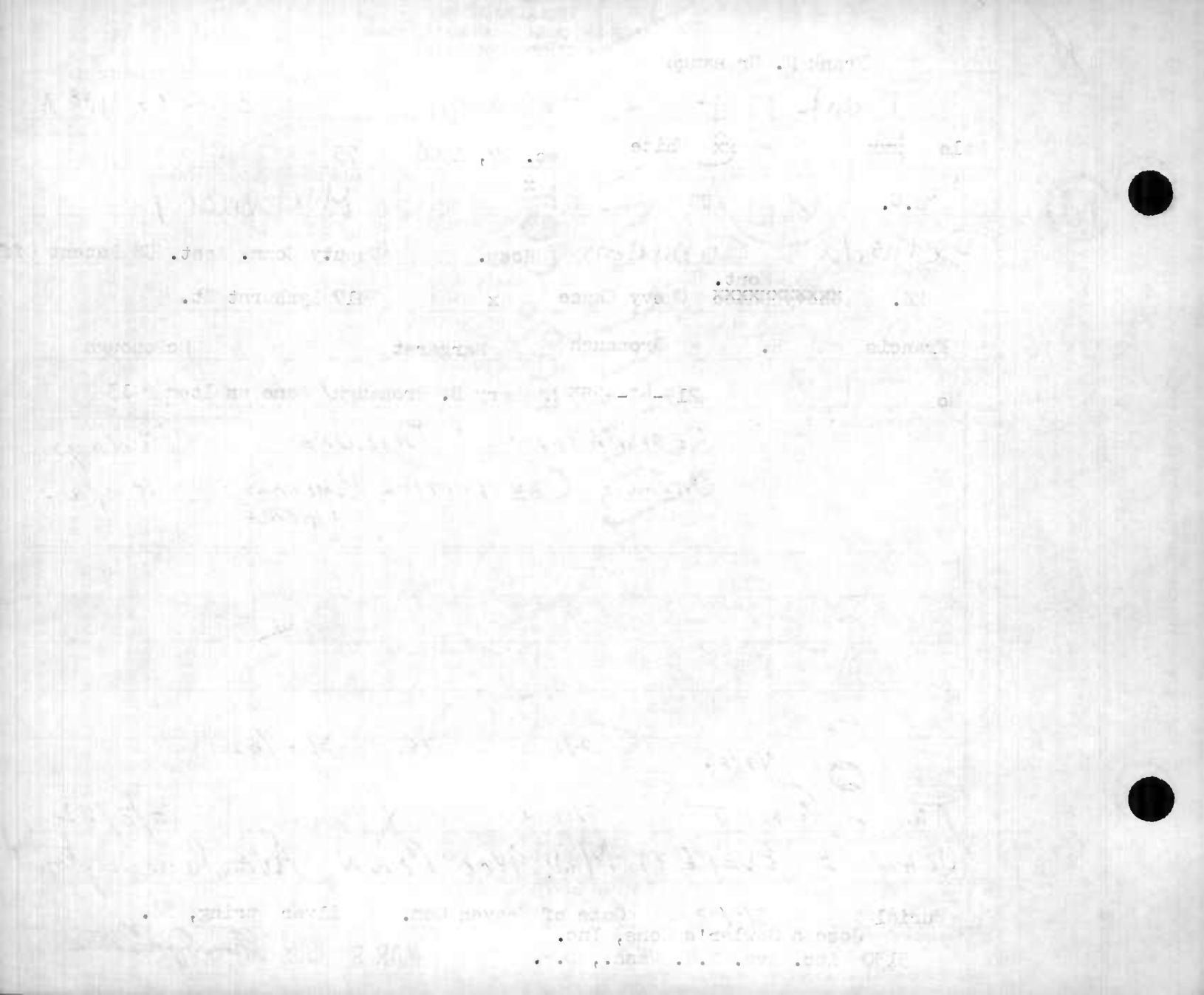
1. DECEASED NAME (TYPE OR PRINT) Brewster, oro			2a. DATE OF DEATH MONTH DAY YEAR 3-5-82		2b. HOUR 12:15AM	
3 SEX F	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR 10/16/1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Asbury Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Maryland, Faithersburg MD.		
10. CITY OR TOWN OF DEATH Faithersburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson health care center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md			13b. COUNTY Montgomery	13c. CITY OR TOWN Faithersburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Goodwin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Crabtree			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 228-16-0206		17. INFORMANT NAME ADDRESS Ron Brewster Enka, N. Carolina		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Colon DUE TO, OR AS A CONSEQUENCE OF (c) Colon APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year 5 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) No V 75				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (the hospital) attended the deceased from above (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)						
22b. SIGNATURE Thos G. Ward		22c. DATE SIGNED 3/5/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward		
22e. ADDRESS 6116 Kohnert Rd, Bethesda, Md		22f. ADDRESS Bethesda, Md		22g. ADDRESS Bethesda, Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 3/5/82		23c. NAME OF CEMETERY OR CREMATORY		
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE James J. [Signature]		
24. FUNERAL DIRECTOR NAME ADDRESS Anatomy Board Balto., Md.		25a. DATE REC'D. BY REGISTRAR MAR 11 1982		25b. REGISTRAR'S SIGNATURE		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Frank H. Bronaugh									
1. DECEASED NAME (TYPE OR PRINT) Frank H Bronaugh						2a. DATE OF DEATH MONTH 3 DAY 28 YEAR 82		7b. HOUR 11:48 A.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Dec. DAY 27 YEAR 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75		8. UNDER 1 YEAR MONTHS 0 DAYS 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Deputy Comm. Asst.		12b. KIND OF BUSINESS OR INDUSTRY US Patent Off	
13a. STATE Md.		13b. COUNTY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7417 Lynhurst St.			
14. FATHER'S NAME FIRST Francis MIDDLE H. LAST Bronaugh				15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE McDonough LAST McDonough					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-42-4253 M		17. INFORMANT ADDRESS Mary B. Bronaugh/ Same as Item # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4960 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 10 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/1 19 76 to 3/2/82 19____, that (I) (we) lost saw the deceased alive on 3/2/82 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John E. Everett				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN E. EVERETT M.D.				22e. ADDRESS 9400 CONN. AVE. Kensington Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring COUNTY Md. STATE			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR MAR 8 1982 REGISTRAR SIGNATURE John J. [Signature]					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

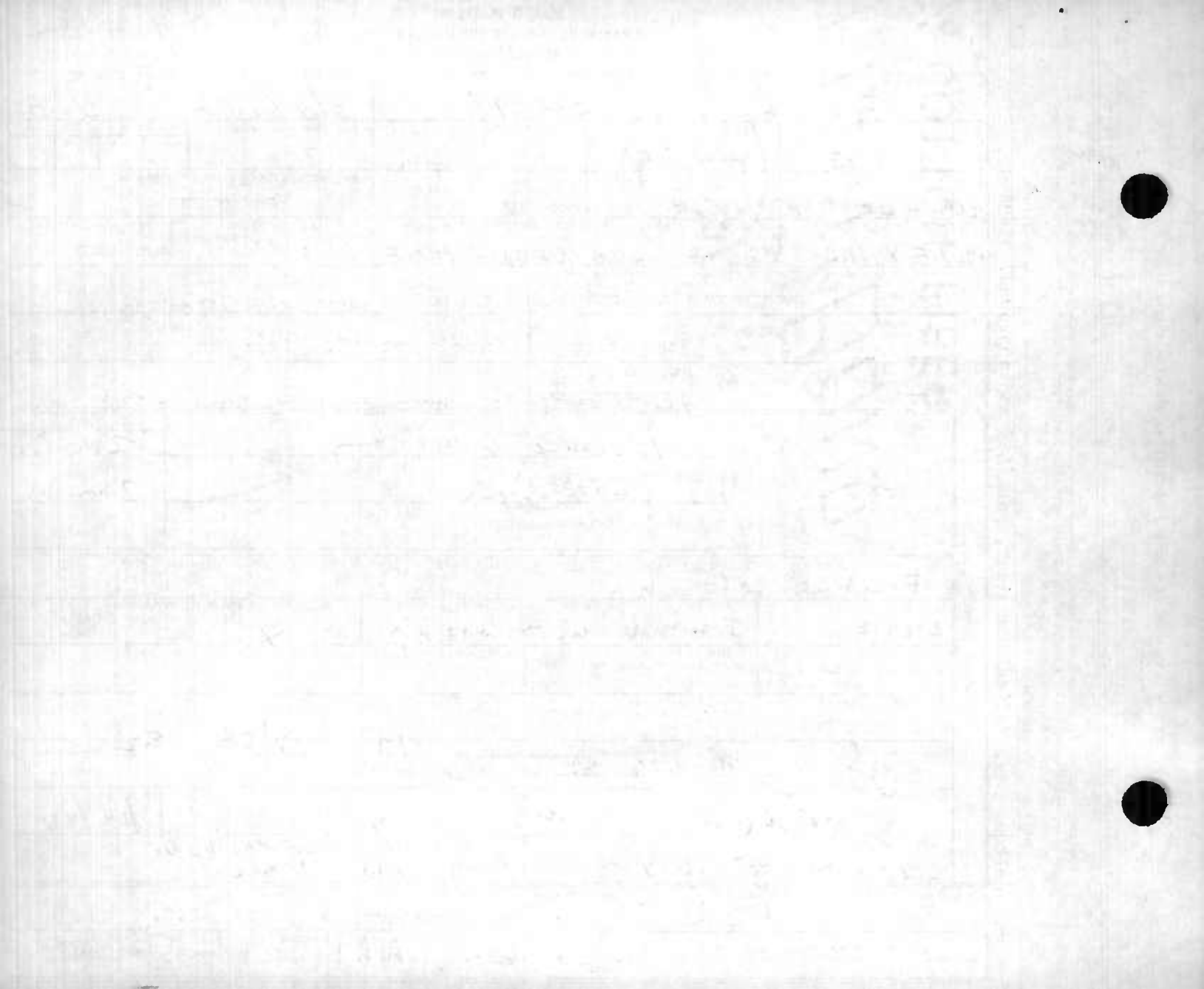
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 has any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. Whelton, Dep. Medical Examiner, notified and approved 03-28-82.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 4 2 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES M. BROWN				2b. HOUR 3:10 A.M.			
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR 4 30 1884		6 AGE (IN YEARS LAST BIRTHDAY) YRS 97	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C. - USA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH OLNEY, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Highland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Theodore F. Schumacher		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antoinette C. Wiegmann		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ---			
16b. SOCIAL SECURITY NO. 578-34-1308		17 INFORMANT ADDRESS Nola Brown - daughter - (same as 13c)					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Advanced Senility</u> 8880 } Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last } (b) <u>Depression</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Fracture Left hip</u>							
19a. DATE OF OPERATION 2/27/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intertrochanteric fx. Left hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED 3/28/82			
22a. I certify that (1) this hospital attended the deceased from above, (2) we (did not) view the body after death		22b. SIGNATURE Lewis Kellert, MD		22c. ADDRESS 18111 Prince Phillip Dr. Olney, Md. 20832		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Kellert, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 31 1982		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR APR 1 1982		25b. REGISTRAR'S SIGNATURE [Signature]		25c. DATE REC'D. BY REGISTRAR APR 1 1982	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 2 4

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Dean Bryan			2a. DATE OF DEATH MONTH DAY YEAR March 8, 1982		2b. HOUR 3:00A	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 24, 1901		
6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dentist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		13. STREET ADDRESS 10401 Grosvenor Place		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE Maryland		14b. COUNTY Montgomery		14c. CITY OR TOWN Rockville		
15. FATHER'S NAME FIRST MIDDLE LAST William C. Bryan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Mauger		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		
16b. SOCIAL SECURITY NO. WW II		17. INFORMANT ADDRESS Miriam E. Bryan, Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adult Respiratory Distress Syndrome</u> 4380 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Chronic Lung Disease with infection</u> (c) <u>Generalized malaise and small stroke</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 5 days. Many years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Diabetes mellitus, Hypertension, Obesity.</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>79</u> to <u>3/8</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>3/8/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Faruk Togo Ozer</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/8/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Faruk Togo Ozer		22e. ADDRESS 11125 Rockville Pike, Rockville, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		
23d. LOCATION CITY OR TOWN Arlington		COUNTY Virginia		STATE		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 15 1982		25b. REGISTRAR'S SIGNATURE <u>Frances Jean Nathan</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE FARM HOUSE

THE FARM HOUSE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO. 8 2 0 7 4 2 5						
1. DECEASED NAME (TYPE OR PRINT) Mabelle B. Buckingham					2a. DATE OF DEATH MONTH DAY YEAR 3-19-82					2b. HOUR 7:35A	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN 29, 1949		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress			12b. KIND OF BUSINESS OR INDUSTRY Restaurant		
13a. STATE md.		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 122701 Virginia Manor Rd.			
14. FATHER'S NAME (FIRST MIDDLE LAST) John Bliss					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Emma C. Jordon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.				16b. SOCIAL SECURITY NO. 213-16-9386		17. INFORMANT ADDRESS Lemuel C. Buckingham same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pneumonia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-16-82	
2765 } CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension										3-16-82	
DUE TO, OR AS A CONSEQUENCE OF (c) Dehydration										3-16-82	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ASCVD, CHF, CAD, Cerebrovascular Disease, Fracture @ femur											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) No				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 3-19-82 , 19____, to 3-19-82 , 19____, that (I) (we) last saw the deceased alive on 3/19/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.											
22b. SIGNATURE MB Petrucci MD DEGREE								22c. DATE SIGNED 3-19-82		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G B Petrucci MD								22e. ADDRESS 9221 Coleville Rd Silver Spring, Md 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/22/82		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park Sykesville, Carroll Md.			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC.						25a. DATE REC'D. BY REGISTRAR MAR 23 1982 REGISTRAR'S SIGNATURE Frances Jan Nathan					
26. ADDRESS 7601 Sandy Spring Rd. Laurel, Md. 20707											

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO.				8 2 0 7 4 2 6			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Eleanor Buganski					2a. DATE OF DEATH MONTH DAY YEAR March 16, 1982			2b. HOUR MIN. 4:20 P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 24, 1956		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 25		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Criminologist		12b. KIND OF BUSINESS OR INDUSTRY Cape May County	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN New Jersey Cape May Woodbine					13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 507 Clay Street 08270		
14. FATHER'S NAME FIRST MIDDLE LAST Leo Buganski					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Switka				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO 156 54 0747		17. INFORMANT ADDRESS Leo Buganski (father) same as patient					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Vasculitis DUE TO, OR AS A CONSEQUENCE OF (b) Systemic Lupus Erythematosus DUE TO, OR AS A CONSEQUENCE OF (c) 7100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 17, 1980 to March 16, 1982 , that (I) (we) last saw the deceased alive on March 16, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (X) (we) view the body after death.									
22b. SIGNATURE DEGREE Daniel G. Malone MD						22c. DATE SIGNED 3/17/82		22d. ADDRESS National Institutes of Health Clinical Center, Bethesda, Maryland 20205	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 20, 1982		23c. NAME OF CEMETERY OR CREMATORY St. Casimir's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodbine, New Jersey		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR MAR 19 1982			

2/11/33

James A. Malone

James A. Malone, 1000 1st St., New York, N.Y.

James A. Malone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 07427	
1. DECEASED NAME (TYPE OR PRINT) Nowa M Butts					2a. DATE OF DEATH MONTH DAY YEAR March 26-82			2b. HOUR 8:25 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 10 1993		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William H. Blocker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Isabel Kelly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 422 54 4800		17. INFORMANT Daughter ADDRESS 120 Center Dr. Clemmie L. Phillips Bethesda, Md.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Artery Thrombosis 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 15 days.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic Congestive Heart failure											
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the undersigned) attended the deceased from March 11 1982 , to March 26 1982 , that (I) (we) lost saw the deceased alive on March 26 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE Augustus B. Aquino, M.D.					DEGREE		22c. DATE SIGNED Mar 27, 1982				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Augustus B. Aquino, M.D.					22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md. 20814						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Forest Hills Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Birmingham, Alabama				
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND					25a. DATE REC'D. BY REGISTRAR MAR 31 1982		25b. REGISTRAR'S SIGNATURE Frances Jean Nathan				

BP

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 11th inst. in relation to the above matter.
The same has been forwarded to the proper authorities for their consideration.
Very respectfully,
J. H. [Signature]

Very truly yours,
J. H. [Signature]

Respectfully,
J. H. [Signature]

0705
BP
DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 2 8			
FOR 1 - STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) William Roaten Byrum				2a. DATE OF DEATH MONTH DAY YEAR March 21, '82		2b. HOUR 5 ⁰⁵ P. M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 30, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Metalsmith		12b. KIND OF BUSINESS OR INDUSTRY Sheet Metal	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST Emory Lafayette Byrum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Roaten			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Sister Emma L. Weaver ADDRESS Same as item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Emphysema</u> 4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 1 yr 10 yr			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 31</u> , 19 <u>79</u> , to <u>March 21</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Feb 21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE <u>Frank J. Mayo, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-21-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Mayo, M.D.		22e. ADDRESS 16220 Frederick Road Gaithersburg, Md. 20877					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 25, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAY 26 1982			
				25b. REGISTRAR'S SIGNATURE <u>Charles J. Walker</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 2 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FANNIE M. CAMPBELL				2a. DATE OF DEATH		2b. HOUR	
3 SEX Female		4 RACE Cauc		5 DATE OF BIRTH MONTH 2 DAY 25 YEAR 96		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST John MIDDLE - LAST Blackwell				15. MOTHER'S MAIDEN NAME FIRST Mame MIDDLE - LAST Matthews			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 179-05-9605D		17. INFORMANT Velma Edwards		ADDRESS 4503 Conifer Lane, Bethesda, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Renal Failure 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) CHF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 5+ years 5+ years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 8/21 19 75 to 3/4 19 82 , that (I) (we) last saw the deceased alive on 1/29 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald G. Geger, M.D.		22e. ADDRESS 12105 Parkcrest Rd Gaithersburg, Md 20878					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/7/82		23c. NAME OF CEMETERY OR CREMATORY Odd Fellows Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Frackville Schuylkill Pa.	
24. FUNERAL DIRECTOR NAME Nice Funeral Home		ADDRESS 9 N. Lehigh Ave. Frackville, Pa. 17931		25a. DATE REC'D. BY REGISTRAR MAR 8 1982		25b. REGISTRAR'S SIGNATURE [Signature]	



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Handwritten notes and a signature at the bottom of the page.

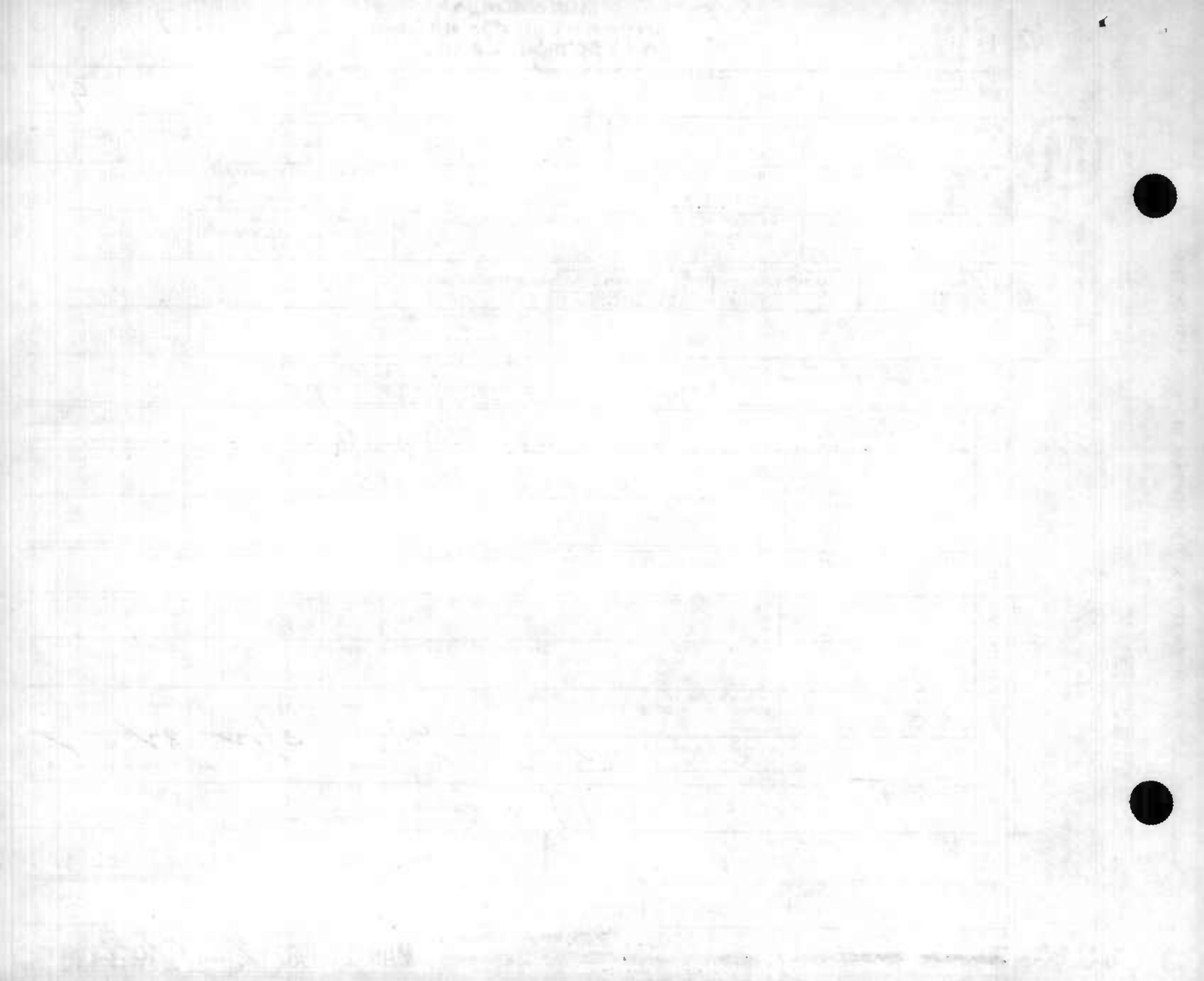
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 4 3 0			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST REBECCA CANTOR				March 12, 1982			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR DEC. 20, 1898		6 AGE (IN YEARS LAST BIRTHDAY) YRS 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14508 Homecrest Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST NATHAN ROSE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 216-40-6367		17. INFORMANT MRS. LILLIAN BURKA 5021 CEDAR LANE BETHESDA, MD 20814				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cordior arrest</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>asphyxiation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>12/1</u> to 19 <u>3/12</u> , that (I) (we) lost saw the deceased alive or above (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Robert Kramer</u> DEGREE				22c. DATE SIGNED 3-12-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRAMER, M.D.	
22e. ADDRESS 8630 Fenton Street; Silver Spring, Md.				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 3-14-82		23c. NAME OF CEMETERY OR CREMATORY CHERNIGOVER (NEW SECT.)		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD		24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC.	
24a. NAME		24b. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215		25a. DATE REC'D. BY REGISTRAR MAR 19 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Smith</u>	



Classified by Dr. Wheeler

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 3 1 REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HAZEL W. CAREY						March 4, 1982				6:25 AM			
3 SEX FEMALE		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1908		6 AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HolyCROSS HOSPITAL				12a. USUAL OCCUPATION Homemaker		12b. KIND OF BUSINESS OR HOME OF WORK FOR MOST OF WORKING LIFE Home					
13a. STATE MARYLAND						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN CHEVY CHASE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7712 KENILWORTH Driveway	
14 FATHER'S NAME Charles Weber				15. MOTHER'S MAIDEN NAME Sophronia Thompson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No				16b. SOCIAL SECURITY NO. 577-10-5465		17. INFORMANT Willard F. Carey, Husband, Same as item #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 Chronic Obstructive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ALL WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Feb 16 to March 4, 1982, and that (I) (we) last saw the deceased alive on March 3, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (we) did not see the body after death, so state.)													
22b. SIGNATURE Stephen M. Hellman				22c. DEGREE PHYSICIAN				22d. DATE SIGNED 3/4/82					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN HELLMAN				22f. ADDRESS 14805 PHYSICIANS LA ROCKVILLE, MD 20850									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE March 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland				24. FUNERAL DIRECTOR ADDRESS				25. REC'D. BY REGISTRAR MAR 8 1982					

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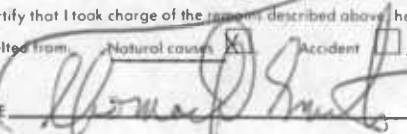

W. 21

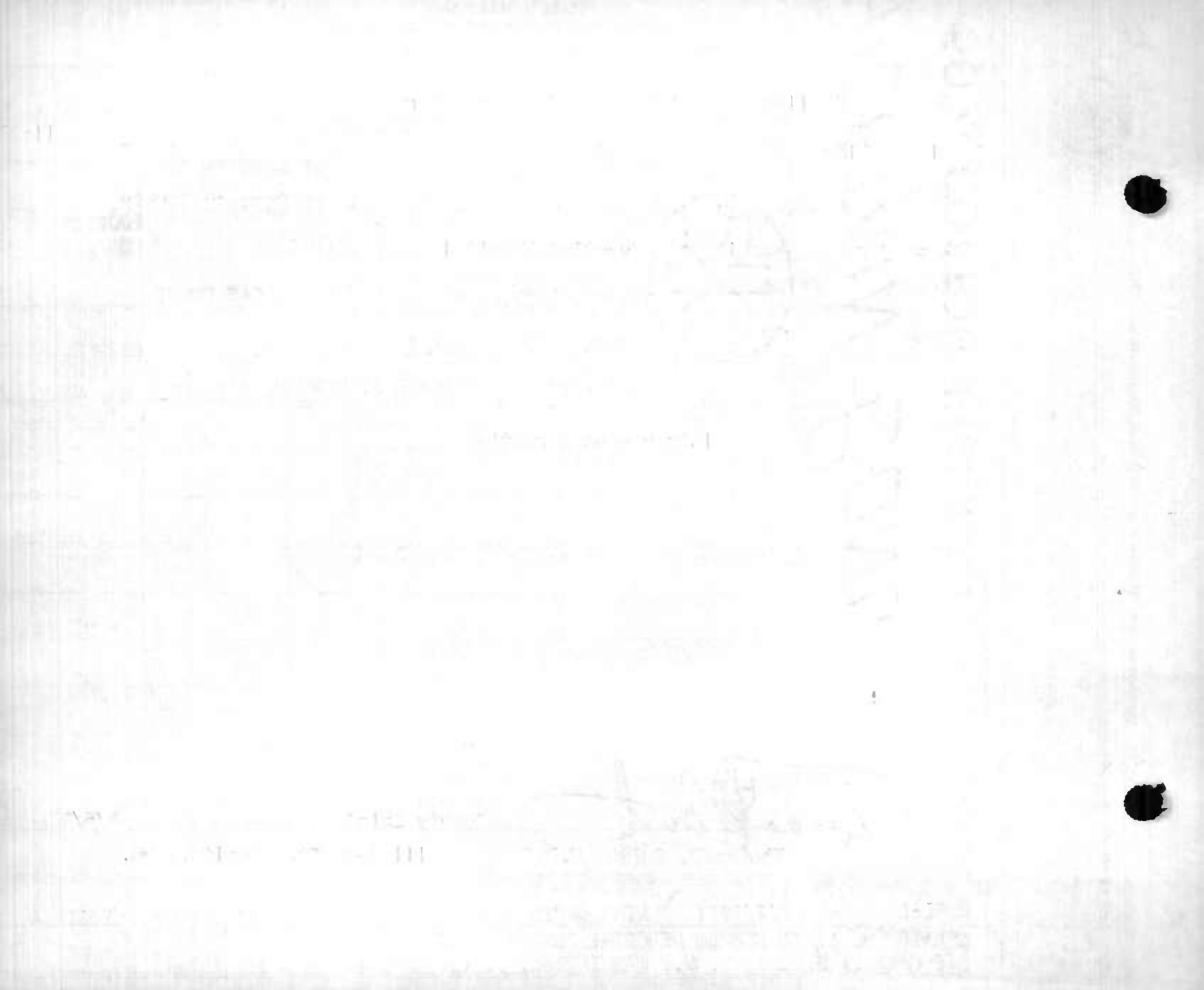
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 7 4 3 2	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shelley Lynn WERMAN Carpenter						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 3 5 19 82		2b. HOUR M 11:27			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR MAY 9, 1958	6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 5 19 82		2d. HOUR P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY		12b. NAME OF BUSINESS COMPANY RECORDING COMPANY			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8209 BRUCAR COURT			
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE R. WERMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PEARL F. BERGER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-74-7149		17. INFORMANT 8209 BRUCAR COURT GEORGE R. WERMAN, GAITHERSBURG, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intravenous narcotism</u> 3049 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the person described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Deputy Chief			MEDICAL EXAMINER		DATE SIGNED 3/6/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/7/1982		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA				
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 3 3

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN S. CARTER JR. MARTIN S. CARTER		2a. DATE OF DEATH MARCH 9, 1982 03-09-82	
3. SEX Male		2b. HOUR 1109 a.m.	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MARCH 05 92	
6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Boys		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2901 Slidell Road Box 30		14. FATHER'S NAME FIRST MIDDLE LAST MARTIN S. CARTER SR.	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE - LEITH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO	
16b. SOCIAL SECURITY NO. 220-38-3726		17. INFORMANT Linda Carter	
17. ADDRESS SAME AS #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 4300 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic bronchitis and Emphysema</u> (c) <u>Temporal Bled Middle cerebral artery aneurysm</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE No June.		22c. DATE SIGNED 3-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KAUDUN NOSSULI		22e. ADDRESS 11500 Old Georgetown Rd. Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MARCH 12, 1982	
23c. NAME OF CEMETERY OR CREMATORY LAYTONSVILLE		23d. LOCATION CITY OR TOWN COUNTY STATE LAYTONSVILLE MONT. MD.	
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR MAR 16 1982	

0302



Temporary Board will work out a way
to handle the situation in a proper
manner.

KAOUN NOZORI 11200 of Georgetown
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 3 4	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas C. Carter						2a. DATE OF DEATH MONTH DAY YEAR 3/10/82		2b. HOUR 10:25AM			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 3 05		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 10 25 00 00			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired auto		12b. KIND OF BUSINESS OR INDUSTRY mechanic			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 30a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10519 St. Paul Street			
14. FATHER'S NAME FIRST MIDDLE LAST Milton Carter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Metz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Hyattsville, Md. 20784 Charles C. Carter 7111 Glenridge Dr.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) none											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) the hospital attended the deceased from Feb 16 19 82 to MAR 10 19 82 , that (2) I last saw the deceased alive on 3/10 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If you did not view the body after death, so state.)											
22b. SIGNATURE Robert J. Lindeman				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Lindeman				22e. ADDRESS 10215 Fernwood Rd. Bethesda, Md. 20034							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/13/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 15 1982		25b. REGISTRAR'S SIGNATURE James J. [Signature]					

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Robert L. Johnson

1931 of the 1st National Bank, New York

Robert L. Johnson

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Frank</i>		MIDDLE		LAST <i>Caruso</i>		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> 3-28-82		2b. HOUR 5:30 PM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 3 17 1912		6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-28-82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Postman		12b. KIND OF BUSINESS OR INDUSTRY Postal Service			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12014 Georgia Avenue,			
14 FATHER'S NAME FIRST MIDDLE LAST Salvatore Caruso				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antonina Rascona							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 577-26-3136		17. INFORMANT ADDRESS Mary Caruso-wife (same as 13 e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Disease</i> 4140 DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Richard L. Whelton</i>				TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED <i>March 28, 1982</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>RICHARD L. WHELTON</i>				ADDRESS <i>1100 Baltimore Ave College Park Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-31, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Hines/Rinaldi Funeral Home Sil. Spr. Md.				25a. DATE REC'D. BY REGISTRAR MAR 30 1982		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove embargoes, Pages 1 and 2 should be filed in the Bureau of Health after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic events, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 4 3 6			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 7b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA M. CELIA				March 22 1982 10:04 a.m.			
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR March 25 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pietro Sapienza		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antonia Murrata		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			
16b. SOCIAL SECURITY NO. 212 30 4609		17. INFORMANT 510 Notley Rd. S.S.Md. Angelo Cella (Son)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic heart DUE TO, OR AS A CONSEQUENCE OF (c) disease			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 70 to 3/18 19 82, that (I) (we) last saw the deceased alive on 3/18 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE (Type or Print) Dr. John Merendino				DEGREE		22c. DATE SIGNED 3/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 11620 Kemp Mill Road S.S.Md.		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/25/82		23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE PG Maryland	
24. FUNERAL DIRECTOR Hines/Rinaldi F.H. 11800 N.H. Ave. S.S.Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 24 1982 James J. Nathan			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 4 3 7			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGEAH M. CHANEY				March 2 1982 12:45 PM			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Sept 30 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Illinois		13b. CITY OR TOWN SALINE		13c. STREET ADDRESS 602 No Mill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Perry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Lewis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NONE			
16b. SOCIAL SECURITY NO. 344-40-175		17. INFORMANT ADDRESS 902 Schindler Dr		17. INFORMANT EFFIE C. ERKMAN Silver Spg Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vasculature thrombosis							30 hours
4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized							10 years
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 1 1982, to March 2 1982, that (I) (we) lost saw the deceased alive on March 2 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M.D. M.D.				22c. DATE SIGNED March 2, 1982		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE H. EIG	
22e. ADDRESS 9801 Georgia Ave Silver Spring Md 20902				22f. DATE REC'D. BY REGISTRAR MAR 5 1982			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-7-1982		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Carle Mills Saline Ill	
24. FUNERAL DIRECTOR NAME W.H. Chambers Co Inc Silver Spg Md							

M.W. Chamberlain Co Inc 2-12-69
8-1-1987 Sakon County-CARL M. W. Chamberlain

No. 374-1018 E. C. Erickson, Jr. & Co.
Lewiston, Idaho
Boise, Idaho

W. L. Moore Saline Corporation -
Box No. 111

U.S.A. National Committee
for the Study of the
History of the U.S.A.
National Committee
for the Study of the
History of the U.S.A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 3 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances G. Choate			2a. DATE OF DEATH MONTH DAY YEAR 3-7-82		2b. HOUR 6:50 A					
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 6, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4619-Norwood Drive	
14. FATHER'S NAME FIRST MIDDLE LAST James F. Graham			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Louise Eads							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 487-50-1387		17. INFORMANT ADDRESS Hamilton Kenner (Son-in-law) Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4140 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 30 years 20 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) generalized arteriosclerosis, stroke										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 1975 , 19____, to date , 19____, that (1) (we) lost saw the deceased alive on 4 March 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Charles W. Thompson MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7 Mar '82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES WATERS THOMPSON			22e. ADDRESS 730-24 N.W. WASH, D.C. 20037							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE March 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002					25a. DATE REC'D. BY REGISTRAR MAR 12 1982		25b. REGISTRAR'S SIGNATURE Thompson			

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 07439							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Burroughs Clapp										2a. DATE OF DEATH MONTH DAY YEAR March 18, 1982		2b. HOUR MIN. 7:30 P.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 31, 1896		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mechanicsville, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD											
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Retirement Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 		12b. KIND OF BUSINESS OR INDUSTRY 									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY St Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 	
14. FATHER'S NAME FIRST MIDDLE LAST Luther Burroughs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Burroughs													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO				16b. SOCIAL SECURITY NO. 220 46 4667		17. INFORMANT ADDRESS Rt. 4, Box 469 Mechanicsville, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4360										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 3 days. 12 years.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 																	
19a. DATE OF OPERATION 				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 											
22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19 to 3/18 , 19 82 , that (I) (we) lost saw the deceased alive on 3/18/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE S. A. Thomas, M. D.				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED March 19, '82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. A. Thomas, M. D.				22e. ADDRESS 4301-48th St. NW Washington, D.C. 20016													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY All Faith Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Charlotte Hall, Maryland									
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown,				ADDRESS Maryland		25a. DATE REC'D. BY REGISTRAR MAR 23 1982		REGISTRAR'S SIGNATURE Francis J. Martin									

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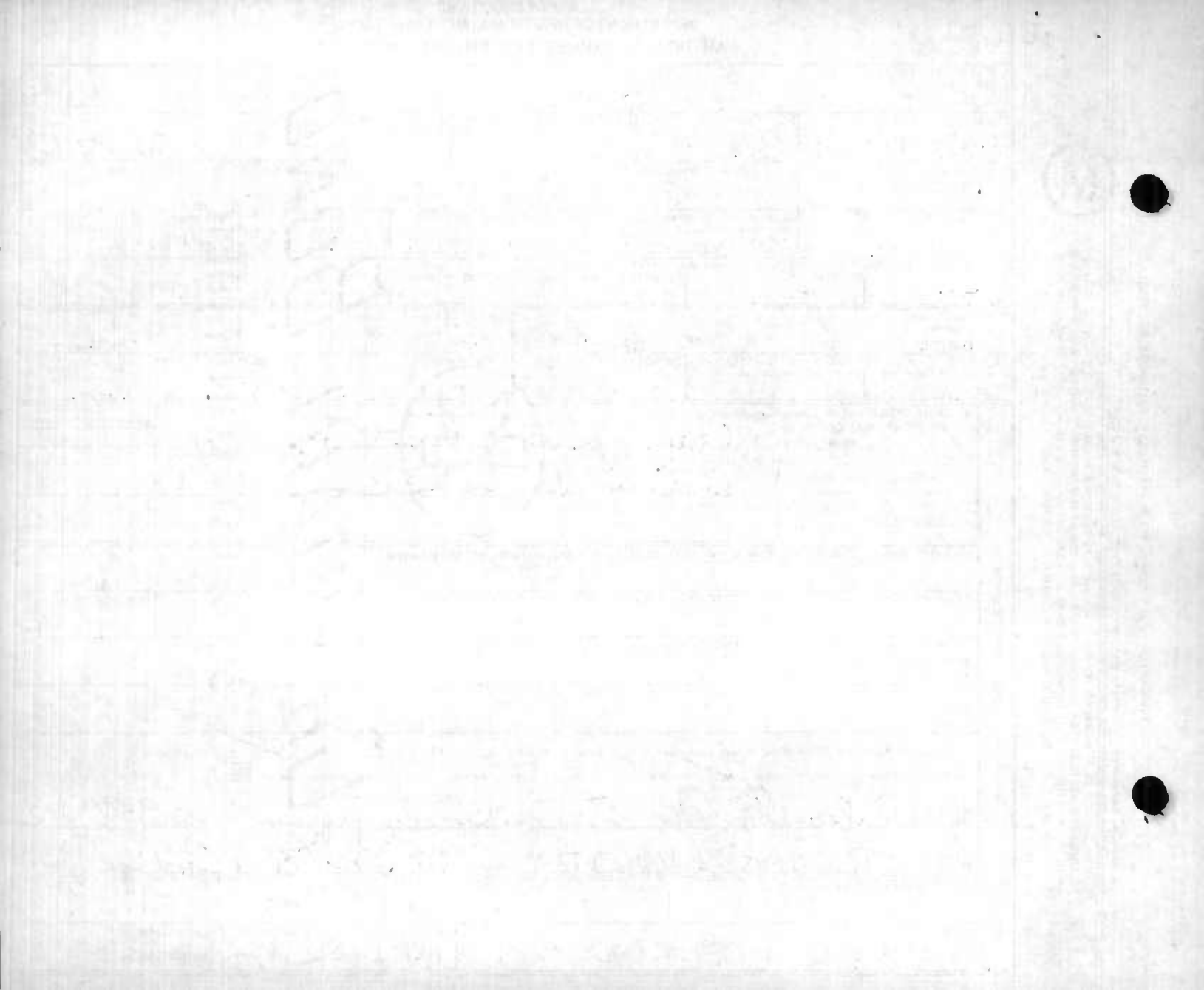
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07440			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROY R. CLARK										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 3/30/1982										2b. HOUR OF DEATH 12:54 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5/22/00		6. AGE IN YEARS (LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YR. MONTHS DAYS 3-30-82		IF UNDER 24 HRS. HOURS MIN. 12:54		2c. DATE PRONOUNCED DEAD 3-30-82										2d. HOUR 12:54 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Olney				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist US Gov't				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland										13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3158 Adderley Court							
14. FATHER'S NAME FIRST MIDDLE LAST Egbert Clark										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Guy Talbert													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None				16b. SOCIAL SECURITY NO. 578 01 2342				17. INFORMANT ADDRESS Edith Clark (Wife) Same as above															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) <u>Arteriosclerotic Coronary</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Richard L. Whelton						TITLE (SPECIFY) Deputy						DATE SIGNED 3-30-82											
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON						ADDRESS 5100 Balt Ave College Park Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/2/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.													
24. FUNERAL DIRECTOR NAME Hines/Rinaldi										ADDRESS 11800 N.H.Ave.S.S.Md.				25a. DATE REC'D. BY REGISTRAR APR 1 1982				25b. REGISTRAR'S SIGNATURE James J. [Signature]					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
Michelle Cloud						XX			3 14 1982			M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Female		Black		7-2-70		11 YRS.						3 14 1982		1:55 a.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Wash., D.C.			U.S.A.						Montgomery County, MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda			Suburban Hospital						Student			School					
13a. STATE												13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Maryland												P.G.		Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 2316 Bright Seat Rd. #4	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
Emile Cloud						Jacqueline Gaines											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
No				n/a				None				Jacqueline Gaines, 2316 Brightseat Rd., #4					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Hypoxemic Encephalopathy																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) Anaphalactic drug reaction																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				10:30 a.m. 3 5 1982				therapeutic misadventure									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				office				5454 Wisconsin Ave., Bethesda, Montgomery Co., Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Virginia L. Dolan				Assistant				3-16-82									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Virginia L. Dolan, M.D.				111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				3-20-82		Maryland National Cem.				Laurel, Maryland							
24. FUNERAL DIRECTOR												25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
VANN & WILLIAMS FUN. HOME, 4804 Ga. Ave., N.W., Wash., D.C.												16 1982		James J. Nathan			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

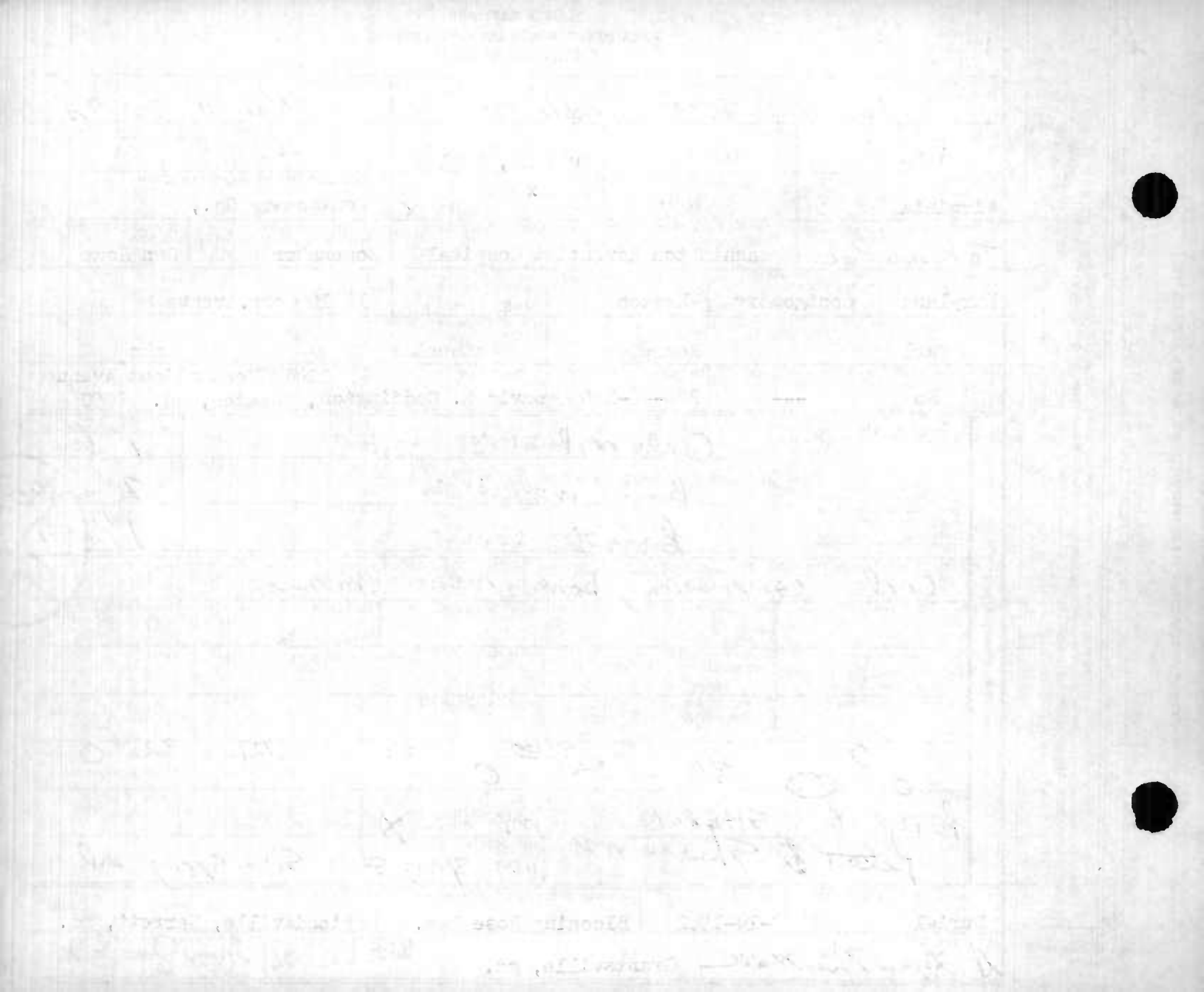
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1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Lyn da Scott Coddington			2a. DATE OF DEATH MONTH DAY YEAR Mar 11 82		2b. HOUR 7A M
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR July 26, 1941	6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.		
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Earl Moore			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Lake		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 228-48-1383	17. INFORMANT David E. Coddington ADDRESS 12418 Connecticut Avenue Wheaton, Md. 20906			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Brain metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Breast Cancer					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 months 1 1/2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Cord compression; bone marrow invasion					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/10 19 80 , to 3/11 19 82 , that (II) (we) last saw the deceased alive on 3/10 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE PETER B. SHERER		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter B. Sherer MD		22e. ADDRESS 1109 Spring St. Silver Spring md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-14-1982	23c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Friendsville, Garrett, Md.		
24. FUNERAL DIRECTOR D. Lynn Newman		ADDRESS Grantsville, Md.	25a. DATE RECEIVED BY REGISTRAR MAR 19 1982		
		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 4 3	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Jesse Colbert						2a. DATE OF DEATH MONTH DAY YEAR Mar. 21 82		2b. HOUR 4²⁵ PM			
3. SEX M		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR October 29, 1897		6. AGE (IN YEARS (LAST BIRTHDAY)) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montg. Co. MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Share Cropper		12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. STATE MD						13b. CITY OR TOWN Prince Georges Upper Marl		13c. STREET ADDRESS Box 4206 Route 301			
14. FATHER'S NAME FIRST MIDDLE LAST Feilder Colbert				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Wells							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-36-8197		17. INFORMANT Julia M. Colbert		ADDRESS Box 4206 Route 301 Upper Marlboro, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency - 1 week DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic CARCINOMA Cx ON - 1 year DUE TO, OR AS A CONSEQUENCE OF (c) 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, Part 1 or Part 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 6 Feb 82 , 19 82 , to 21 Mar 82 , 19 82 , that (1) <input checked="" type="checkbox"/> I saw the deceased alive on 21 Mar 82 , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.											
22b. SIGNATURE Thomas A. Bensinger MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/22/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas A. Bensinger				22e. ADDRESS 7676 New Hampshire Ave Langley Park Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/25/82		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Prince Georges MD			
24. FUNERAL DIRECTOR NAME ADDRESS Rollins Funeral Home, Inc. 4339 Hunt Place, N.E., Washington, D.C.						24a. DATE REC'D. BY REGISTRAR MAR 26 1982					

MEDICAL CERTIFICATION

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October 1, 1947

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Washington

Washington, D.C.

Prince George's Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE—8 2 0 7 4 4 4 CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CATHARINE T. COLLIER				2a. DATE OF DEATH MONTH DAY YEAR 3 5 82		2b. HOUR 7:15 PM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR May 14 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montgy.		13c. CITY OR TOWN Spencerville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Taney		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Quentel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16a. SOCIAL SECURITY NO. 577-01-0781		17. INFORMANT ADDRESS Mrs. Nancy Fait 8717 Green Pastures Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16d							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>5 Mar 1982</u> to <u>8 Mar 1982</u> , and that (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.							
22b. SIGNATURE <u>Michael Bobowicz</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6 Mar 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Bobowicz				22e. ADDRESS 1120 New York Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-8-1982		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto Md.	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons				ADDRESS 4905 York Rd. Balto. Md. 21212		25a. DATE REC'D. BY REGISTRAR MAR 9 1982	

100% COTTON

16. Monday, November 10, 1968
 17. Tuesday, November 11, 1968
 18. Wednesday, November 12, 1968
 19. Thursday, November 13, 1968
 20. Friday, November 14, 1968
 21. Saturday, November 15, 1968
 22. Sunday, November 16, 1968
 23. Monday, November 17, 1968
 24. Tuesday, November 18, 1968
 25. Wednesday, November 19, 1968
 26. Thursday, November 20, 1968
 27. Friday, November 21, 1968
 28. Saturday, November 22, 1968
 29. Sunday, November 23, 1968
 30. Monday, November 24, 1968
 31. Tuesday, November 25, 1968
 32. Wednesday, November 26, 1968
 33. Thursday, November 27, 1968
 34. Friday, November 28, 1968
 35. Saturday, November 29, 1968
 36. Sunday, November 30, 1968

37. Monday, December 1, 1968
 38. Tuesday, December 2, 1968
 39. Wednesday, December 3, 1968
 40. Thursday, December 4, 1968
 41. Friday, December 5, 1968
 42. Saturday, December 6, 1968
 43. Sunday, December 7, 1968
 44. Monday, December 8, 1968
 45. Tuesday, December 9, 1968
 46. Wednesday, December 10, 1968
 47. Thursday, December 11, 1968
 48. Friday, December 12, 1968
 49. Saturday, December 13, 1968
 50. Sunday, December 14, 1968
 51. Monday, December 15, 1968
 52. Tuesday, December 16, 1968
 53. Wednesday, December 17, 1968
 54. Thursday, December 18, 1968
 55. Friday, December 19, 1968
 56. Saturday, December 20, 1968
 57. Sunday, December 21, 1968
 58. Monday, December 22, 1968
 59. Tuesday, December 23, 1968
 60. Wednesday, December 24, 1968
 61. Thursday, December 25, 1968
 62. Friday, December 26, 1968
 63. Saturday, December 27, 1968
 64. Sunday, December 28, 1968
 65. Monday, December 29, 1968
 66. Tuesday, December 30, 1968
 67. Wednesday, December 31, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				82 07445			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME FIRST MIDDLE LAST <u>Florence Collins</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>03 20 82</u>		2b. HOUR <u>8 52 P M</u>	
3. SEX <u>FEMALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>JULY 27, 1894</u>		6. AGE (IN YEARS (LAST BIRTHDAY)) <u>87</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>York, Penn.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>Shady Grove Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>registered nurse</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>	
13a. STATE <u>Maryland</u>				13b. CITY OR TOWN <u>Baltimore C. Baltimore</u>		13c. STREET ADDRESS <u>4 - E 32nd Street</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Horace Epley</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Lillie Herr</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>				16b. SOCIAL SECURITY NO. <u>220-30-1574</u>		17. INFORMANT ADDRESS <u>Rev. Richard Reichard 9701 Vets Dr. Rockville</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular failure</u> 5908 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> (c) <u>Cerebral aneurysm</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 29, 1966</u> to <u>March 20, 1982</u> that (I) (we) lost saw the deceased alive on <u>March 20, 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Thomas E. Dooley, M.D.</u>				22c. DATE SIGNED <u>3/21/82</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas E. Dooley, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>March 24, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery, Baltimore, Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Hysong Funeral Home 1300 N St. N.W. Wash. D.C.</u>				24b. RECEIVED BY REGISTRAR <u>MAR 29 1982</u>		24c. SIGNATURE <u>James J. [Signature]</u>	

CONFIDENTIAL - SECURITY INFORMATION
EX-100

SECRET - SECURITY INFORMATION

100-37, 100-38

CONFIDENTIAL - SECURITY INFORMATION

CONFIDENTIAL - SECURITY INFORMATION

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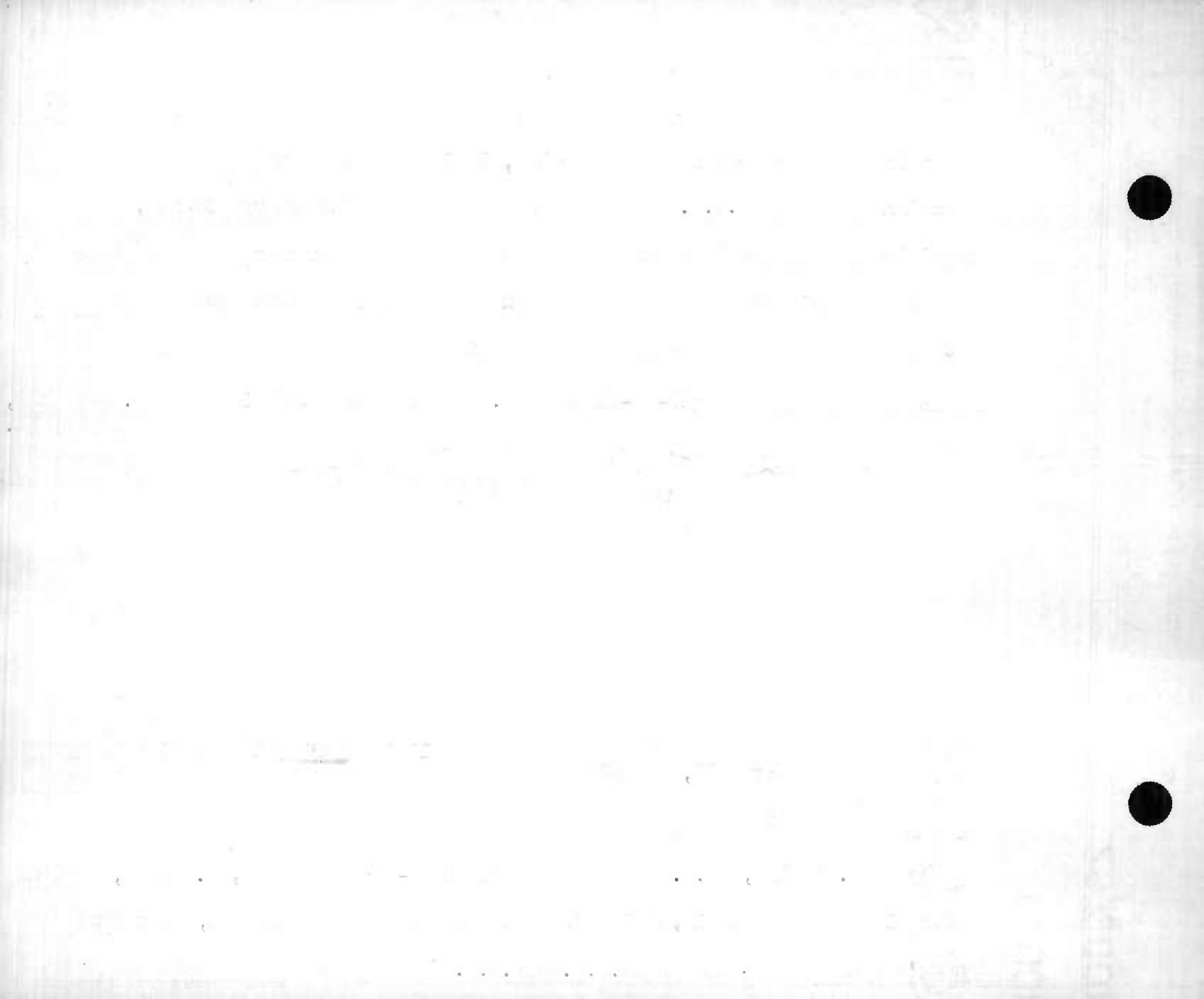
CONFIDENTIAL - SECURITY INFORMATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Ethel		M.		Conary				3 12 1982 4:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
female		caucasian		April 6, 1883		98 years			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
England		U.S.A.				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		National Lutheran Home		Homemaker		at home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Baltimore		Baltimore				1718 Edgewood Road	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John Winterbottom		Eliza White							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
no		217-03-0143		Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) ASCVD CHF									
DUE TO, OR AS A CONSEQUENCE OF (b) CAD ASCVD									
DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 19 1962 to March 11 19 82, that (I) (we) lost saw the deceased alive on March 11 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (not) what gives the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Thomas E. Dooley, M.D.		2901 Olney-Sandy Springs Rd. Olney, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		March 16, 1982		Prospect Hill Cemetery		Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hysong's Funeral Home		1300 N St. N.W. Wash. D.C.		MAR 17 1982					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 07447									
1. FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH						2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT) William A. Connell, Sr.						2c. DATE ESTIMATED 3 2 19 82						2d. HOUR 10 45 AM							
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Sept. 21, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD March 2 19 82		2d. HOUR 10 45 AM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Rockville.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier				12b. KIND OF BUSINESS OR INDUSTRY Postal Svc.							
13a. STATE Maryland												13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10820 Middleboro Dr.	
14. FATHER'S NAME (FIRST MIDDLE LAST) James B. Connell						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Mary Sharp													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. W.W. 1 130-20-2860		17. INFORMANT ADDRESS George J. Connell, Item 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8880 Coronary Insufficiency Acute - DUE TO, OR AS A CONSEQUENCE OF Cardio-Vascular Disease - (b) Fracture of Rt. Hip - (c) Fracture of Rt. Hip -												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																			
19a. DATE OF OPERATION 2-22-82				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Repair of Fr. of Hip.						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR 3 30 P.M. 2-20 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fall. of frame. Fracture of Hip.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home.				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10820 Middleboro Dr. Damascus Mont. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED March 2, 1982							
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Mar. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY L.I. National Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Pinelawn, New York									
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAR 4 1982		25b. REGISTRAR'S SIGNATURE											

2028 2 2

March 3 1972

Memorandum

TO : Mr. Tolson

FROM : Mr. [illegible]

SUBJECT :

Re :

Coronary Interventional Aortic

Coronary Vascular Disease

Procedure of [illegible]

Report of [illegible]

2-22-72

For 2-20-72 [illegible]

X

1-2-72 [illegible]

X

X

John A. [illegible]

Report

March 3 1972

Mr. Tolson

Mr. [illegible]

Mr. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

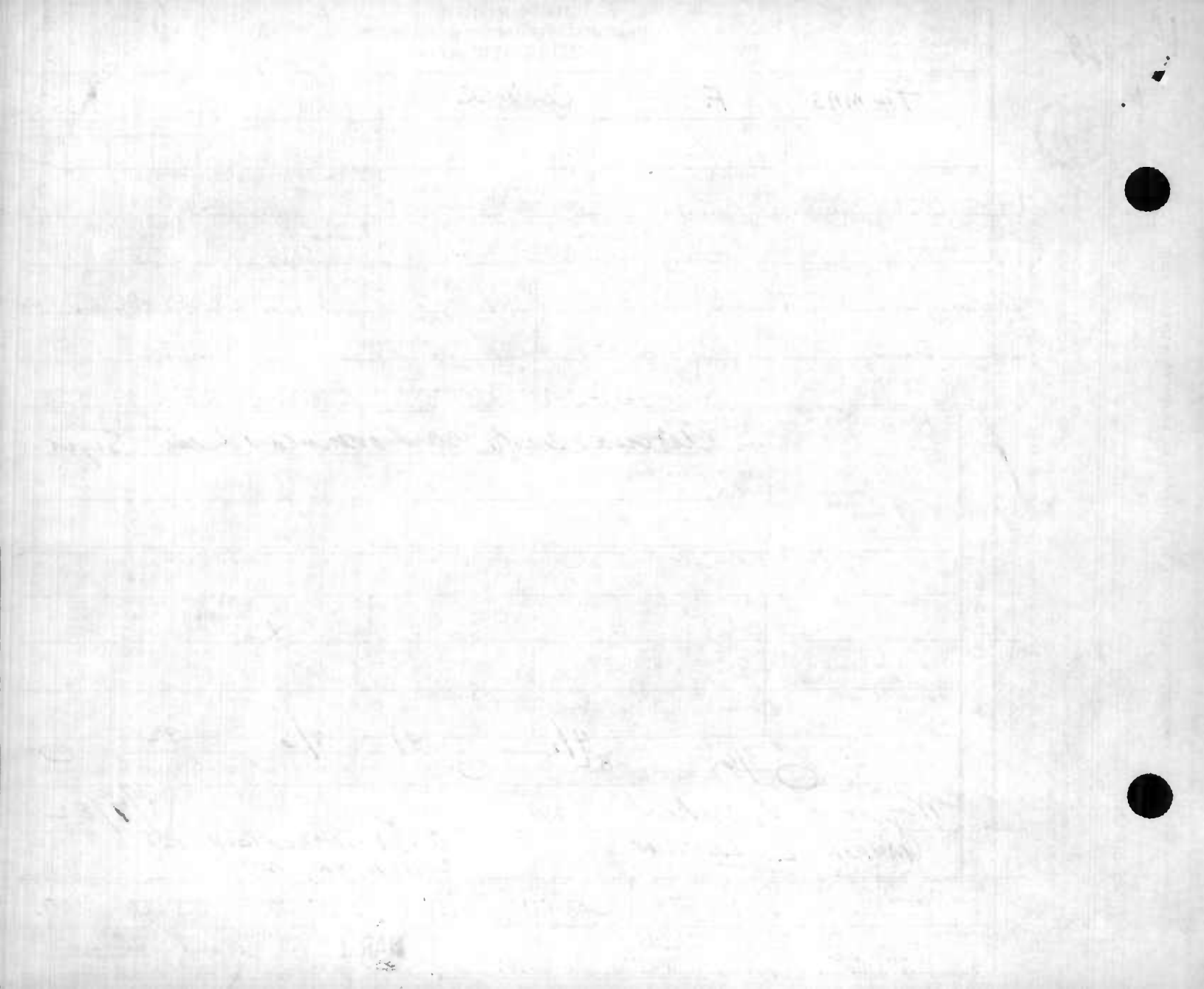
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 4 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS FRANCIS CONNOR			2a. DATE OF DEATH MONTH DAY YEAR MARCH 6 1982		2b. HOUR 7:35 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG 3 1898		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WHEATON MANOR CARE		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETAIL DRUGGIST		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		
14. FATHER'S NAME FIRST MIDDLE LAST JAMES CONNOR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE McGUIRE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 217-32-1834		17. INFORMANT ADDRESS DOROTHY V. CONNOR SAME AS 13 WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: b) _____ c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/6 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 2309 SHOREFIELD RD WHEATON, MD.		
22a. I certify that (I) (this hospital) attended the deceased from 4/1 1982 to 3/6 1982 , that (I) (we) first saw the deceased on 3/6 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.						
22b. SIGNATURE Myron L. Lenkin		DEGREE MD		22c. DATE SIGNED 3/8/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN		22e. ADDRESS 2309 SHOREFIELD RD WHEATON, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/9/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		
23d. LOCATION SUITLAND		23e. COUNTY PRI GEORGE		23f. STATE MD.		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D BY REGISTRAR MAR 12 1982		
				25b. REGISTRAR'S SIGNATURE Thomas J. ...		



O HOSPITAL OR ATTENDING PHYSICIAN: The information obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 7 4 4 9			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
3. SEX				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STREET ADDRESS				13b. STREET ADDRESS				13c. CITY OR TOWN			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
17. INFORMANT				18. SOCIAL SECURITY NO.				19. DATE OF OPERATION			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION				22a. I certify that (I) (this hospital) attended the deceased from [] to [] 19 [] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
22e. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION				24. FUNERAL DIRECTOR			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S NAME			
Maggie (NMN) Conroy				3/8/82				10 ⁵⁵ PM			
Female				Caucasian				Aug 6 1901			
England				England				Montgomery MD.			
Takoma Park				Washington Adventist Hospital				Housewife			
Maryland				Montgomery				Ashton			
Ernest nmnn Connor				Sarah nmnn Unknown				17958 Pond Road			
No				None				215-52-9752			
Iris Conroy				Ashton, Md. 20861				4100			
PART 1: DEATH WAS CAUSED BY				IMMEDIATE CAUSE (a)				DUE TO, OR AS A CONSEQUENCE OF			
Congestive Failure				DUE TO, OR AS A CONSEQUENCE OF				Myocardial Infarction			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION				22a. I certify that (I) (this hospital) attended the deceased from 3-2-82 to 3-8-82, that (I) (we) lost the deceased alive on 3-8-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE			
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION				24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S NAME				25d. REGISTRAR'S ADDRESS			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 5 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) IDA LILLIAN COOPER				2a. DATE OF DEATH MONTH DAY YEAR March 24, 1982		2b. HOUR 3:20pm	
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR Aug. 25, 1894		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.	
14 FATHER'S NAME FIRST MIDDLE LAST Morris Aaron Krupnick				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-42-2672		17 INFORMANT ADDRESS Rockville, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Urinary tract infection DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Organic Brain Syndrome							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from August 1978 to March 24, 1982 , that (1) (I) lost saw the deceased alive on March 18, 1982 , and that (1) (my own) opinion of death occurred on the date and hour and from the causes stated above (1) (I) did not view the body after death.							
22b. SIGNATURE Herbert S. B. Baraf MD				DEGREE MD		22c. DATE SIGNED 3/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert S. B. Baraf MD				22e. ADDRESS 8750 Georgia Avenue; Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-25-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville, Md.	
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels;				ADDRESS Rockville, Md.		25a. DATE REC'D BY REGISTRAR MAR 25 1982	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

NOTES FROM KIRPNIK

NO ----- 219-42-2

Ref
Kvill
tv

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, a view of the body after death is required. If item 18 is marked on item 19, a view of the body after death is required.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 07451	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) Miriam Cooperman						2a. DATE OF DEATH MONTH DAY YEAR 3 14 82		2b. HOUR 5P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 10 21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE md.		13b. COUNTY Mont.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3602 Sandy Court			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Fine				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tillie Cohen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 044-12-0105		17. INFORMANT ADDRESS Maryland Jerome Cooperman-3602 Sandy Ct., Kensington,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Adenocarcinoma										1 Year.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/18 , 19 82 , to 3/14 , 19 82 , that (I) (we) lost saw the deceased alive on 3/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) not view the body after death.											
22b. SIGNATURE Paul W. Johnson Jr.				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul W. Johnson, Jr., MD				22e. ADDRESS 6111 Executive Blvd., Rockville, Md. 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3-16-82		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney, Maryland			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels				ADDRESS 1170 Rockville Pike		25a. DATE REC'D. BY REGISTRAR MAR 17 1982		25b. REGISTRAR'S SIGNATURE [Signature]			

17 MAY 1968

17 MAY 1968

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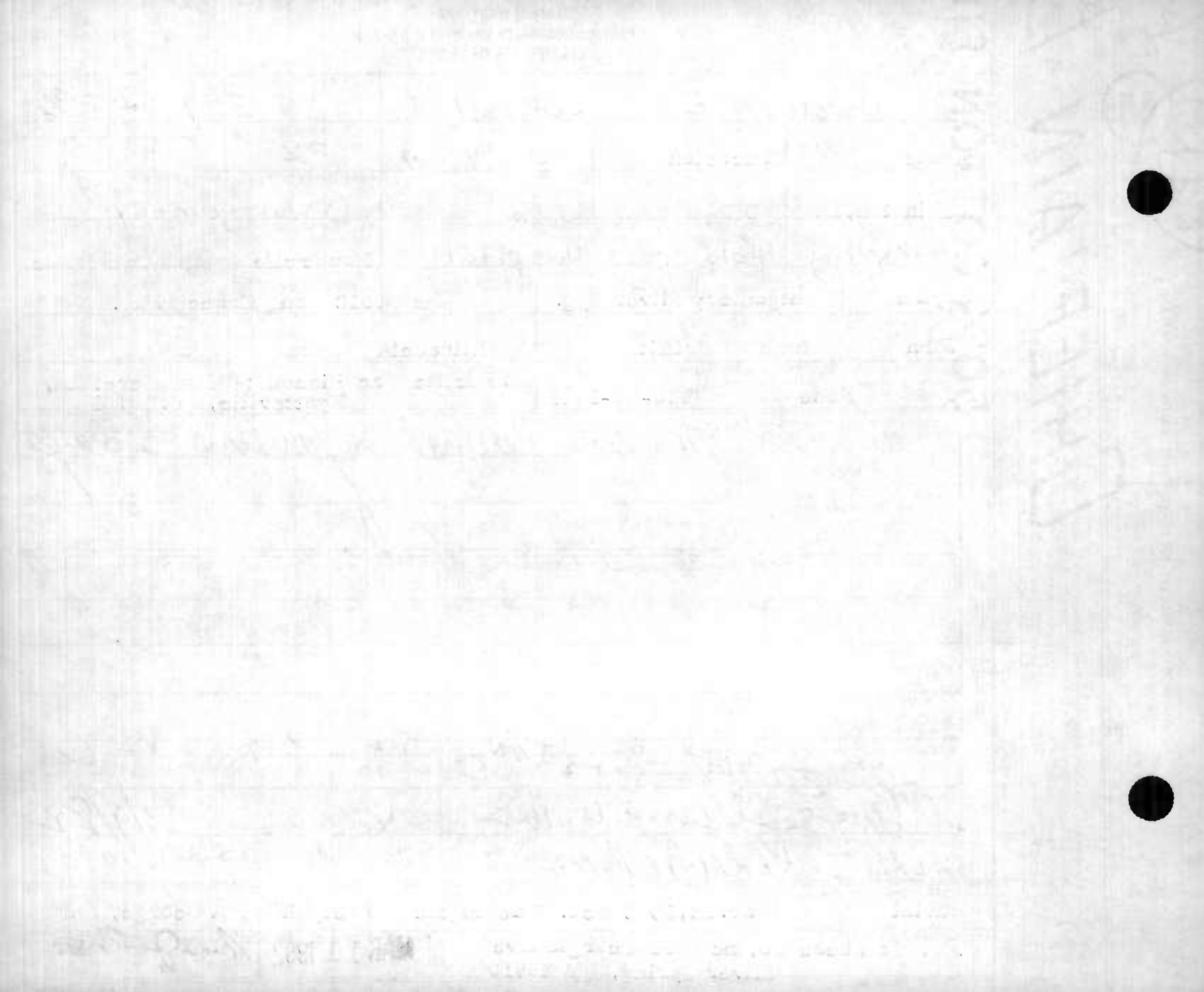
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Dorothy E. CORDELL					3 9 82 8 1/2 M				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Caucasian		12 21 99		82		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Housewife		Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					13d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland Montgomery Silver Spg.					13e. STREET ADDRESS				
					9312 Long Branch Pky.				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
14a. FIRST 14b. MIDDLE 14c. LAST					15a. FIRST 15b. MIDDLE 15c. LAST				
John nm Griffith					Elizabeth nm Adams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				
No None					220-07-3061				
17. INFORMANT					ADDRESS				
R. Lucille Mac Kinnon					2405 Amherst Rd, Hyattsville, Md. 20783				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Massive Cerebral Infarction									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) this hospital attended the deceased from 19 82 to 3/9 19 82 and that in my opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so we did not see the body after death.)									
22b. SIGNATURE DEGREE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
22e. ADDRESS									
ALAN I. KERMAIER, MD 9801 GEORGIA AVE. SS MD 20902									
23a. BURIAL, CREMATION, REMOVAL									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION									
Burial Mar. 12, 1982 Geo. Washington Adelphi Pr. George, Md									
24. FUNERAL DIRECTOR									
W.W. Chambers Co, Inc 8655 Georgia Ave Silver Spring, Md 20910									
25a. TIME REC'D. BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									
MAR 11 1982									

MEDICAL CERTIFICATION

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2200 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after burial with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 82 07453			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 3 25 82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Royal Crist				2b. HOUR 0235M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 16 95		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker		12b. KIND OF BUSINESS OR INDUSTRY Bank System	
13a. STATE Maryland		13b. COUNTY Montgom.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clifford Crist		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		16. STREET ADDRESS 89 Oak Shade Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS Gaithersburg, Maryland 20878 Carmine Shaw 89 Oak Shade Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) shock DUE TO, OR AS A CONSEQUENCE OF (b) GI bleeding DUE TO, OR AS A CONSEQUENCE OF (c) prob. peptic ulcer 5334							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) senile dementia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/24, 1982, to 3/24, 1982. I saw the deceased alive on 3/24, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.)							
22b. SIGNATURE (Type or Print) S. Wolosky MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Mar. 25 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Wolosky MD		22e. ADDRESS 15 E Dec Pk Dr Gaithersburg MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar 27 82		23c. NAME OF CEMETERY OR CREMATORY Woodhill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Franklin Ohio	
24. FUNERAL DIRECTOR NAME Pearson's Funeral Home, Falls Church, Va.		DATE REC'D BY REGISTRAR MAR 29 1982		SIGNATURE (Type or Print) Thomas J. Gaithersburg			

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

I am sorry to hear that you are not satisfied with the results of the examination. I have been very anxious to see that the work was done to the best of my ability, and I am sure that the results are as good as can be expected under the circumstances.

I have been very anxious to see that the work was done to the best of my ability, and I am sure that the results are as good as can be expected under the circumstances. I have been very anxious to see that the work was done to the best of my ability, and I am sure that the results are as good as can be expected under the circumstances.

RECEIVED - MAY 11 1888

RECEIVED - MAY 11 1888

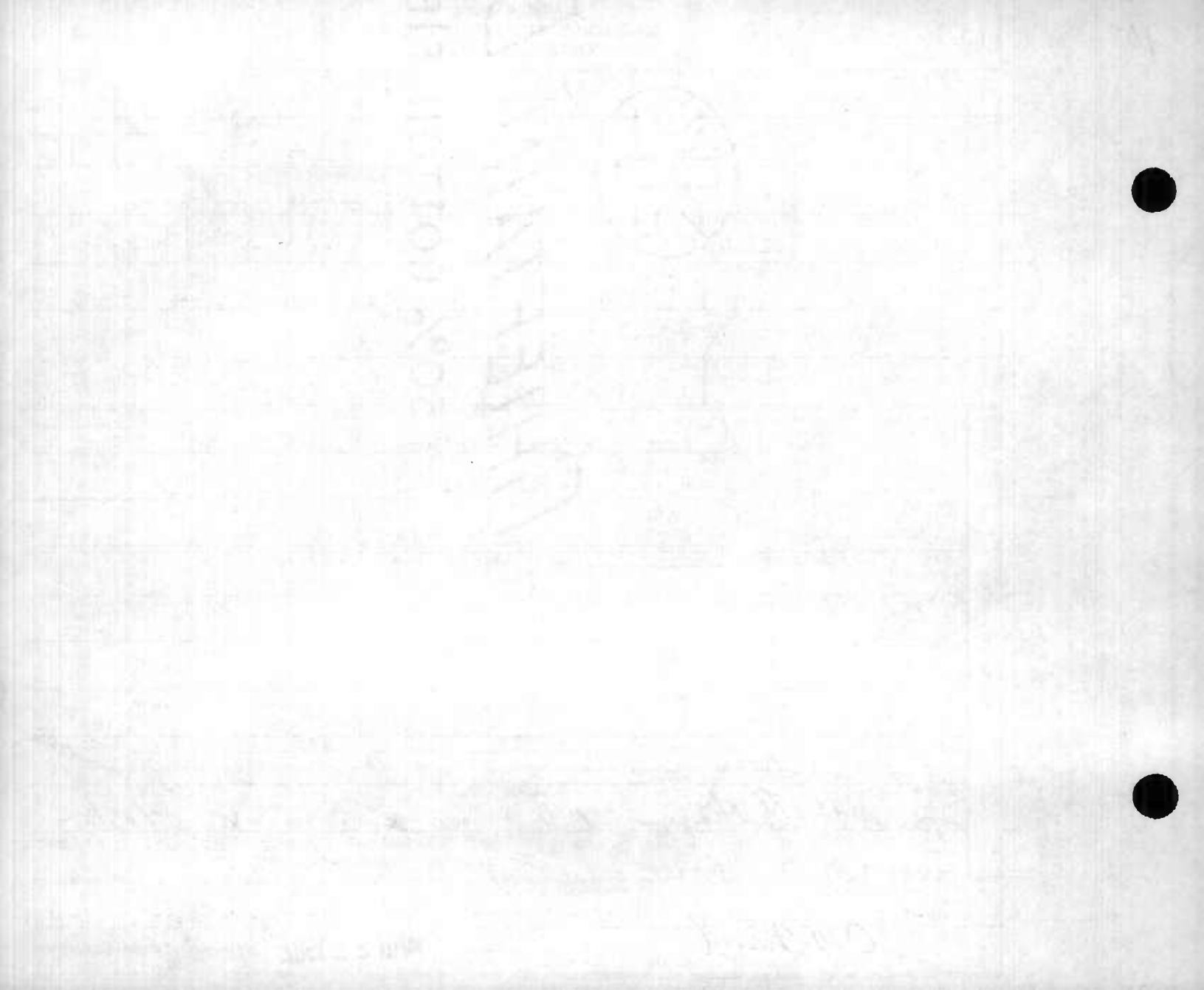
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8 2 0 7 4 5 4				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DOROTHY ORTIZ CROSBY					2a. DATE OF DEATH MONTH DAY YEAR March 25, 1982			2b. HOUR 12:50A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 13, 1910		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 71 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Takoma, Wash.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Hecht Co.	
13a. STATE Virginia		13b. COUNTY ✓		13c. CITY OR TOWN Arlington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5649 8th St., North 22205	
14. FATHER'S NAME FIRST MIDDLE LAST Guy Mc Clure				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST 7504 Parkwood Ct, 304 Falls Church, VA 22042					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 226-44-8085		17. INFORMANT ADDRESS Ms. Marlys Bernal (daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) COPD, Acute Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Lymphocytic Leukemia Approximate interval between onset and death: 5 and days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 19, 19 82 to March 25, 19 82 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 25, 19 82 , and that in xx (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) xxx view the body after death.									
22b. SIGNATURE James H. Shelhamer				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 3/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Shelhamer				22e. ADDRESS Clinical Center, National Institutes of Health, Bethesda, MD 20205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 27		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax Virginia			
24. FUNERAL DIRECTOR NAME Murphy Home-Arlington				24b. ADDRESS 4510 Wilson Blvd, Arl. Va. 22203		25a. DATE REC'D. BY REGISTRAR MAR 31 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FANLEY E. CUDMORE			2a. DATE OF DEATH MONTH DAY YEAR MARCH 31 1982		2b. HOUR 2 30 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUG 2, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SHIPPING FOREMAN		12b. KIND OF BUSINESS OR INDUSTRY AMSTERDAM PRIN	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 13220 BETTY LANE 20904	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY CUDMORE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH COPP		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 096-10-4994		17. INFORMANT ADDRESS VIOLA E. CUDMORE SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular collapse 4149 DUE TO, OR AS A CONSEQUENCE OF (b) cardiac arrhythmias - stroke and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) diffuse coronary artery disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1974 , 19 3/30 , to 82 , that (I) (we) lost saw the deceased alive on 3/25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not), show the body after death.					
22b. SIGNATURE Joseph M. Solinas		DEGREE MD		22c. DATE SIGNED 3/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH M. SOLINAS		22e. ADDRESS SILVER SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/3/82		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE AMSTERDAM MONT MD.		24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLV. D. W., SILVER SPRING, MD. 20901			
25a. DATE REC'D. BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 82 07456									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Espie Lee Curtis						2a. DATE OF DEATH MONTH DAY YEAR March 20 1982		2b. HOUR M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 8 1908		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 74		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 517 Pinewood Road				12a. USUAL OCCUPATION (TYPE OLD WORK FOR MOST OF WORKING LIFE) Retired Animal Caretaker		12b. KIND OF BUSINESS OR INDUSTRY NIH+US Gov't	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 517 Pinewood Road	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence H. Curtis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Young					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-18-7060		17. INFORMANT ADDRESS Marguerite E. Curtis Same as items 13 a-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio resp. Arrest 1539 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of Colon DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-26- 19 81 , to 3/20 19 82 , that (I we) last saw the deceased alive on 1/25 19 82 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I we) did not view the body after death.									
22b. SIGNATURE Carol Bender				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 3/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carol L. Bender				22e. ADDRESS 11510 Old Georgetown Rd. Rockville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.						25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 23 1982			
1331 Rockville Pike Rockville, Maryland									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or other health official must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 5 7			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) X Virginia A. Cuzzolina				2a DATE OF DEATH MONTH, DAY, YEAR X March 18, 1982		2b HOUR 7:35 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 24 1923		6 AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH X Montgomery County MD.	
10 CITY OR TOWN OF DEATH X Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) X Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE Maryland				13b COUNTY Montgomery		13c CITY OR TOWN Kensington	
14. FATHER'S NAME FIRST MIDDLE LAST Charles C. Nickola				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Gustafson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 185-14-6695		17 INFORMANT ADDRESS Frank Cuzzolina same as 13c	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Breast Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Carcinoma Breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a DATE OF OPERATION <u>Jan 28-1976</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Breast Cancer</u>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the physician) attended the deceased from <u>April</u> , 19 <u>76</u> , to <u>March 18</u> , 19 <u>82</u> , that (I) (the physician) saw the deceased alive on <u>March 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE <u>James W. Egan M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>3/19/82</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES W. EGAN</u>				22e ADDRESS <u>5413 Cedar Lane - Bethesda, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE <u>March 22, 1982</u>		23c NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d LOCATION CITY OR TOWN COUNTY STATE <u>Altoona Pennsylvania</u>	
24 FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</u>				25a DATE RECEIVED BY REGISTRAR <u>MAR 24 1982</u>			

RECEIVED

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

82 07458

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST John C Davis			2a. DATE OF DEATH MONTH DAY YEAR Mar. 26 1982		2b. HOUR 12:45 P	
3 SEX male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Nov. 17 1904		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS. MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Govt. Print. O.
13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring	
14 FATHER'S NAME FIRST MIDDLE LAST Henry T. Davis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Ellen Jones			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 215-44-8643		17 INFORMANT Margaret K. Davis Wife Same as 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic renal disease (c) arteriosclerosis						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 3/15/82 to 3/26/82 , that (I) (we) last saw the deceased alive on 3/26/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE EDWARD A. LEVIN		DEGREE M.D.		22c. DATE SIGNED 3/26/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD A. LEVIN		22e ADDRESS 8530 FENTONS R				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Bloomfield Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE New Bloomfield Perry Pa.		24 FUNERAL DIRECTOR NAME Francis J. Collins		25a. DATE REC'D. BY REGISTRAR MAR 31 1982		
25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]		25c. REGISTRAR'S NAME Thomas J. [Signature]				

CONFIDENTIAL

CONFIDENTIAL

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CONFIDENTIAL

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CONFIDENTIAL

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 5 9

1. FOR STATE REGISTRAR		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) <i>Muriel ESTHER DAW</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>3-31-82</i>	
3. SEX <i>FEMALE</i>		2b. HOUR <i>5P M</i>	
4. RACE <i>CAUCASIAN</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>71</i>	
5. DATE OF BIRTH MONTH DAY YEAR <i>APRIL 17, 1910</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ENGLAND</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY COUNTY MD</i>	
7b. CITIZEN OF WHAT COUNTRY? <i>UNITED KINGDOM</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>FASHION CONSULTANT</i>	
10. CITY OR TOWN OF DEATH <i>BETHESDA</i>		12b. KIND OF BUSINESS OR INDUSTRY	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN HOSPITAL</i>		13a. STREET ADDRESS <i>10011 BROOKMOOR DRIVE 20901</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>	
13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN McCARTNEY</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ANNIE CAIRNS</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>215-58-7629</i>	
17. INFORMANT <i>PAMELA SEATER</i>		ADDRESS <i>SAME AS 13 DAUGHTER</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Small Cell Lung</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1991</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>month</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>NO</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3/24 1982</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <i>was</i> hospital attended the deceased from <i>3/24</i> , 19 <i>82</i> , to <i>3/31</i> , 19 <i>82</i> that (I) <i>did</i> last saw the deceased alive on <i>3/31</i> , 19 <i>82</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (If I <i>did not</i> view the body after death.)			
22b. SIGNATURE <i>Stephen Newman</i>		22c. DATE SIGNED <i>4/1/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>STEPHEN NEWMAN</i>		22e. ADDRESS <i>BETHESDA, MARYLAND</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>4/2/82</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ALEXANDRIA VIRGINIA</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		25. DATE REC'D. BY REGISTRAR <i>APR 8 1982</i>	
ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>		REGISTRAR'S SIGNATURE <i>Jan Virginia</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint handwritten text at the bottom of the page, including what appears to be a signature and date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 6 0																			
1. FOR STATE REGISTRAR					REG. NO.																								
1. DECEASED NAME (TYPE OR PRINT)					FIRST			MIDDLE		LAST			2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR						
EDITH M DEGROOT													3-31-82								654 P M								
3. SEX					4. RACE					5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					IF UNDER 1 YEAR		IF UNDER 1 YEAR		IF UNDER 1 YEAR					
Female					Black					12 13 13					68					MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH														
Guyana					Guyana										Montgomery County MD.														
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY														
Silver Spring					Holy Cross Hospital					Housewife					Owner Home														
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. STATE					13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?					13e. STREET ADDRESS									
MD					Mont					SS					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					8005 Eastern Dr.									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																								
FIRST					MIDDLE					LAST					FIRST					MIDDLE					LAST				
Unk					Unk																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS														
NO					NO					21992-5093					Kenneth W. Cowell					9214 Columbia Blvd Silver Spring									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
IMMEDIATE CAUSE (a) Sudden Myocardial CA																													
1579																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Disruptive Genital Injury																			
										(c) Carcinoma of Prostate																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
Stroke R Side. Abdominal Hemorrhage Gastric Fistula.																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
12-8-81					Carcinoma Prostate					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
					HOUR A.M. MONTH DAY YEAR																								
					P.M. 19																								
21d. INJURY OCCURRED					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION																			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										STREET					CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from										11-26 19 81, to 3/31/82 19 82, that (I) (we) lost																			
saw the deceased alive on 3/31/82 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated																													
22b. SIGNATURE										DEGREE																			
W. W. Ferguson										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS																			
W. W. Ferguson										344 Univ Blvd W SS MD																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION														
Burial					4-3-1982					Gate of Heaven					Silver Spring, Mont Md														
24. FUNERAL DIRECTOR					NAME					ADDRESS					25a. DATE REC'D. BY REGISTRAR														
W. W. Chambers Co					8655 Georgia St					APR 7 1982					25b. REGISTRAR'S SIGNATURE														

RECEIVED
JAN 20 1964

EDITH M. ROBERTS

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

1000 1st St. S.W.
Albuquerque, N.M. 87102

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 6 1

1- FOR
STATE
REGISTRAR

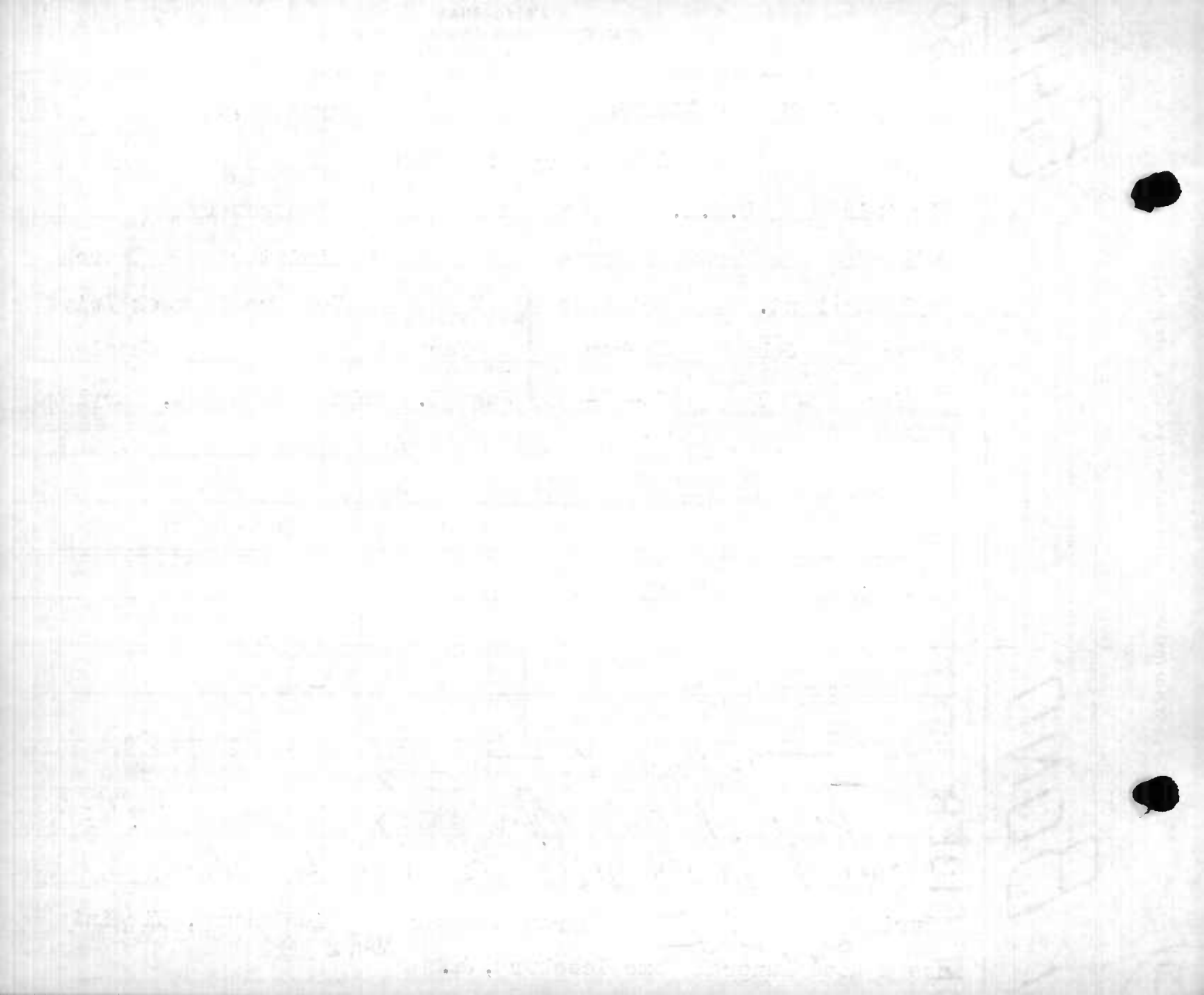
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN WILLIAM DECKER			2a. DATE OF DEATH MONTH DAY YEAR March 17, 1982			2b. HOUR 3:01 AM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 13 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Church	
13a. COUNTY Mont.		13b. CITY OR TOWN Bethesda		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 4703 Broad Brook Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Walker John Decker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Chesley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT John L. Decker		ADDRESS Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF with congestive failure (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 5 yrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Lymphatic Leukemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 18 July 1977 to 17 March 1982 , that (I) (we) last saw the deceased alive on 16 March 1982 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)							
22b. SIGNATURE Michel M. Healy M.D.				DEGREE M.D.		22c. DATE SIGNED 3/17/82	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Michel M. HEALY, M.D.				22c. ADDRESS 5652 Shields Dr., Bethesda, MD, 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/20/82		23c. NAME OF CEMETERY OR CREMATORY Sharon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Middleburg, Virginia	
24. FUNERAL DIRECTOR NAME Muse & Reed Funeral Home				ADDRESS Leesburg, Va.		25a. DATE RECEIVED BY REGISTRAR MAR 23 1982	
				25b. REGISTRAR'S SIGNATURE Frances J. Nathan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 6 2							
1. FOR STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
Bessie HANEY DelleTT			March			3			1982			5 40P M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.		
Female			Caucasian			March 18, 1895			86			MONTHS			DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Washington DC			United States						Montgomery County, MD								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Gaithersburg			Wilson Health Care Center						School Teacher			Education					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Virginia			None			Alexandria			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1405 Wake Forest Drive					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
Thomas F. HANEY			Nellie Brooke														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			212 24 2508			Son			Robert H. Dellett			Same as item 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis										1 Day							
4340 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis										10 yrs.							
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
			HOUR A.M. MONTH DAY YEAR														
			P.M. 19														
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION											
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 4/4/81 19 to 3/3/82 19, that (I) (we) lost saw the deceased alive on 3/18/82 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (yes) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Henry C. Scruggs MD									3/3/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
HENRY C. SCRUGGS MD			5413 Cedar Lane Bethesda Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION								
Burial			6, 1982			Glenwood Cemetery			Washington, D.C.								
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND			MAR 8 1982			Name Jones											

BP

THE UNIVERSITY OF CHICAGO
LIBRARY

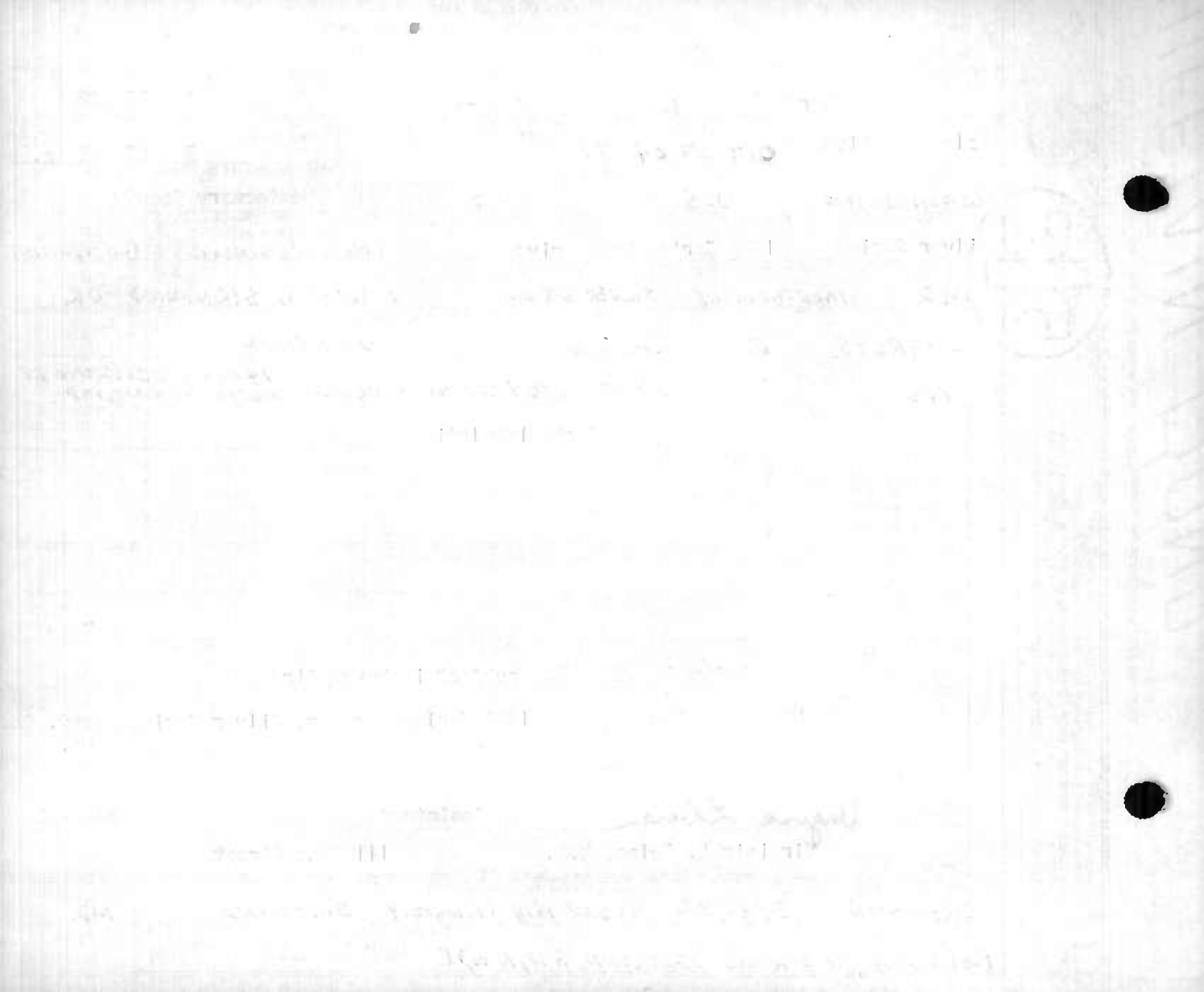
1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025

1950 1951 1952 1953 1954 1955 1956 1957 1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984 1985 1986 1987 1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

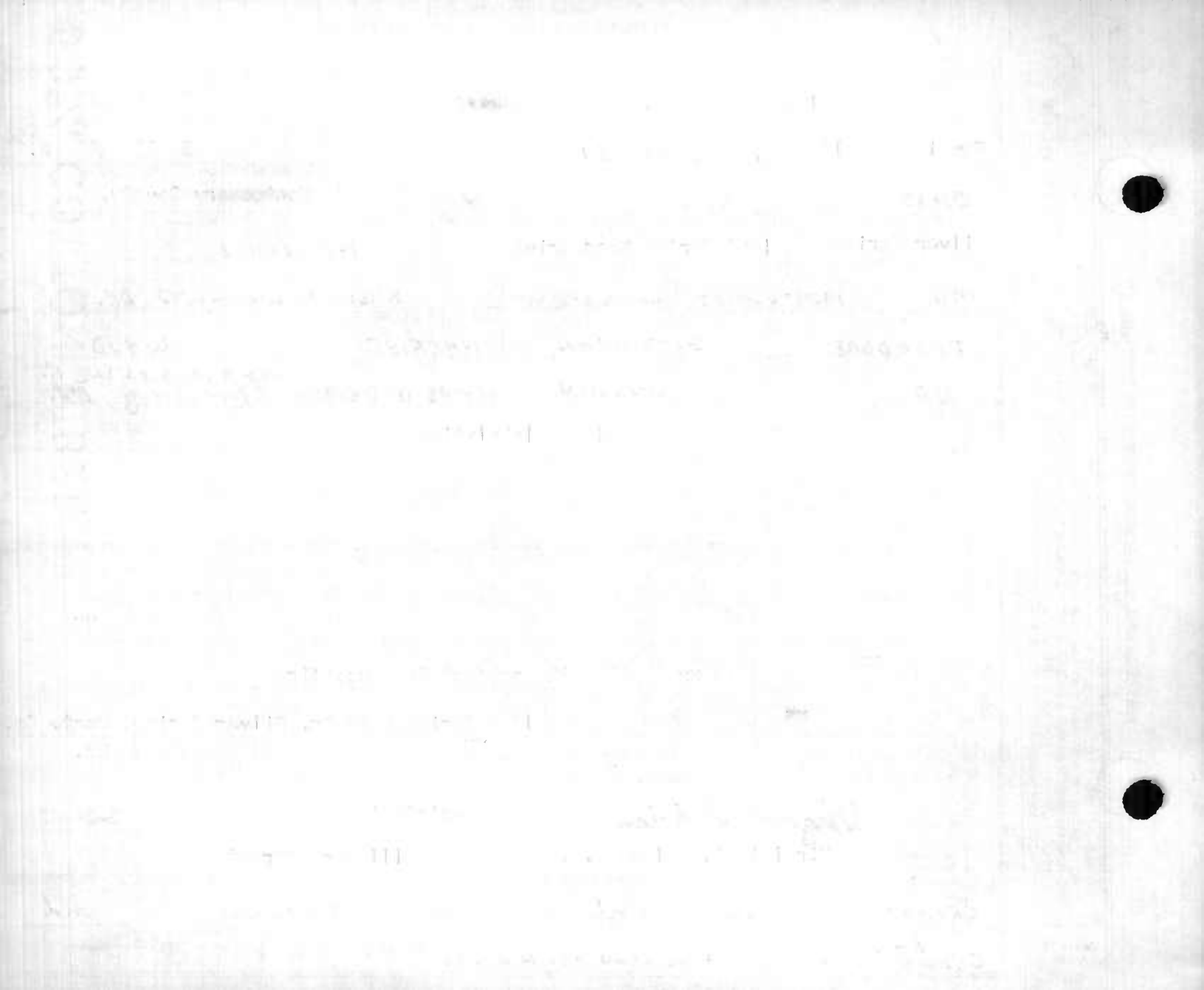
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 0 7 4 6 3	
1. DECEASED NAME (TYPE OR PRINT) George N. DeMoss						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 3 DAY 23 YEAR 1982		2b. HOUR M 5:50			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 29 04 77 YRS.	6. AGE (IN YEARS) (LAST BIRTHDAY) 77 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 23 1982	2d. HOUR M 5:50					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1605 Spring Wood Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT				
13a. STATE MD.		13b. CITY OR TOWN MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1605 N. SPRINGWOOD DR.			
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES B. DeMoss				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 287-03-2864		17. INFORMANT ADDRESS 14513 COBBLESTONE DR WAYNE A. DEMOSS SILVER SPRING, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke Inhalation 8902 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00 3 23 19 82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject in house fire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1605 Spring Wood Dr., Silver Spring, Mont. Co. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan			M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 3-24-82		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 3/24/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE SUTCLAND MD.			
24. FUNERAL DIRECTOR NAME R & R CREMATION SERVICES			ADDRESS 3520 CONN. AVE. N.W.			25a. DATE REC'D. BY REGISTRAR APR 5 1984			25b. REGISTRAR'S SIGNATURE		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 07464	
1. DECEASED NAME (TYPE OR PRINT) Helen K. DeMoss						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		2b. HOUR <input type="checkbox"/>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 22 01		6. AGE (IN YEARS) (LAST BIRTHDAY) 81 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 23 1982		7d. HOUR <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO				7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1605 Spring Wood Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1605 N. SPRING WOOD DR.		
14. FATHER'S NAME FIRST MIDDLE LAST THEODORE GUTENSOHN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET WAUD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNKNOWN		17. INFORMANT ADDRESS WAYNE A. DeMoss 14513 COBBLESTONE R. Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Smoke Inhalation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) 8902 DUE TO, OR AS A CONSEQUENCE OF (c) 8902 DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:00 PM 3 23 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in house fire					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1605 Spring Wood Dr., Silver Spring, Mont. Co.					
22a. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion Md. death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan						TITLE (SPECIFY) Assistant		DATE SIGNED 3-24-82			
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 3/24/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE SWITZLAND md	
24. FUNERAL DIRECTOR NAME R & R CREMATION SERVICES ADDRESS 3520 CONN. AVE. N.W. DC						25a. DATE REC'D. BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 7 4 6 5	
1. DECEASED NAME (TYPE OR PRINT) Dorothy C. DeSilva						2a. DATE KNOWN OF DEATH ESTIMATED Mar 12 1982		2b. HOUR 4 M			
3. SEX Female	4. RACE Cauca.	5. DATE OF BIRTH MONTH DAY YEAR Sept. 2, 1899	6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD March 12 1982	2d. HOUR 1250					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pine Hill, NY		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.						
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3429 S. Leisure World Blvd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adj. Dept.		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3429 S. Leisure World Blvd					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Cole				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie Miller							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 557 32 8860		17. INFORMANT Alan W. DeSilva		ADDRESS Columbia, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Cardiovascular Disease 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Richard L. Whelton				TITLE (SPECIFY) Deputy				DATE SIGNED March 12 1982			
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON				ADDRESS 7100 Baltimore Ave College Park							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE March 14, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia				23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAR 18 1982		25b. REGISTRAR'S SIGNATURE James J. Nathan					



REMOVED

SECTION

NO. 1

10

11

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17
(VR A15 ME (5))
15M 2/80

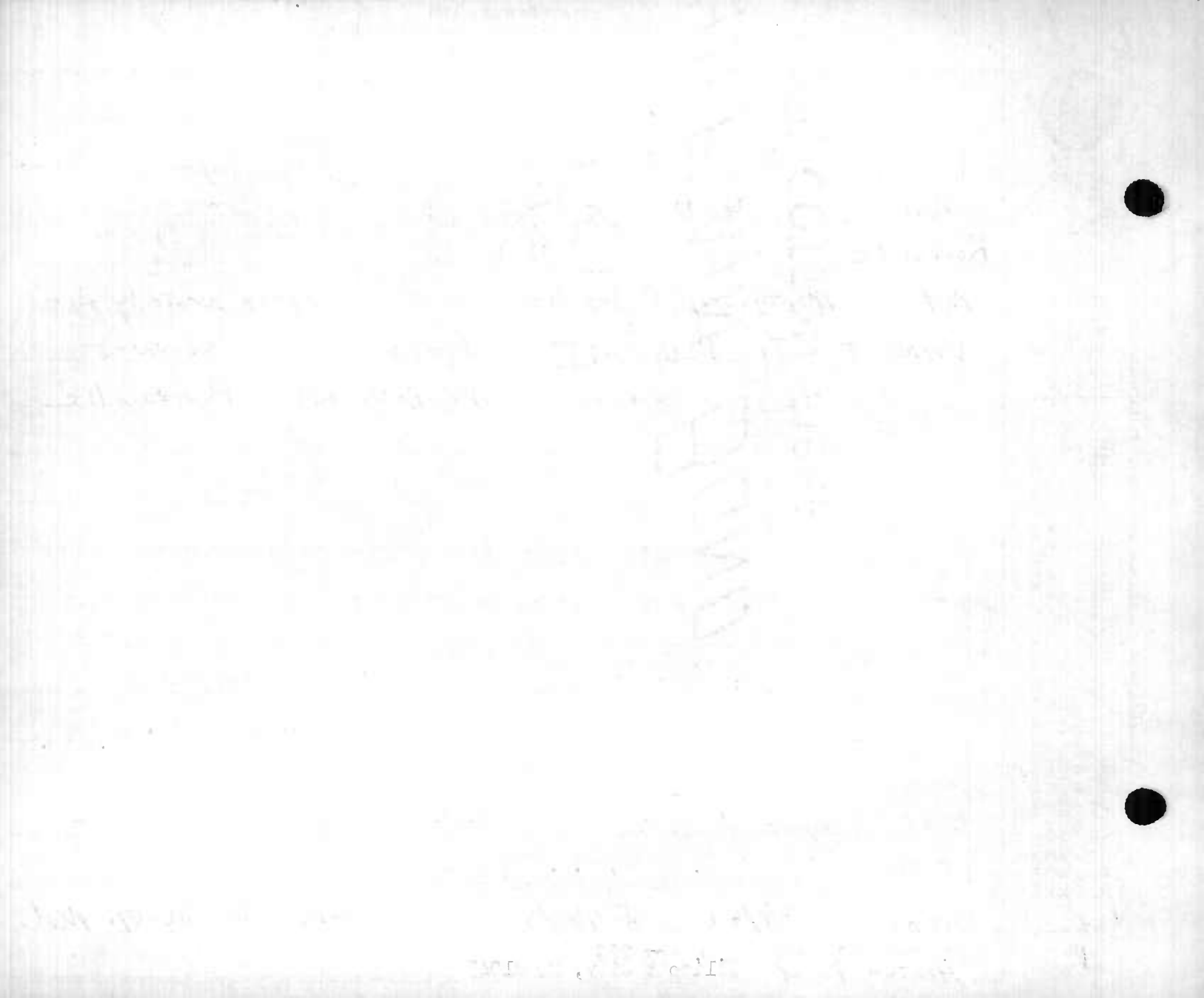
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alexander N. Devriendt			20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3 2 1982			26. HOUR 8:00 P.M.		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR OCT. 29 1977	6. AGE (IN YEARS) (LAST BIRTHDAY) 2 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	21. DATE PRONOUNCED DEAD MONTH DAY YEAR 3 2 1982		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.			13b. COUNTY Montgomery	13c. CITY OR TOWN Poolesville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 19908 Westerly Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST VINCENT J. DeVriendt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Wimmer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS Mr. DeVriendt Poolesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 5:45 P.M. 3 2 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell into swimming pool			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19908 Westerly Drive, Poolesville, Montgomery Co., Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 3-3-82		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/82		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION CITY OR TOWN COUNTY STATE Barnesville Montg. Md.		
24. FUNERAL DIRECTOR SLACK Funeral Home Hilton Funeral				25a. DATE REC'D. BY REGISTRAR MAR 10 1982		25b. REGISTRAR'S SIGNATURE Name J.		

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-1650M (1/81)
(VRA 15, 4)1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 6 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA H. DEWITT			2a. DATE OF DEATH MONTH DAY YEAR 3-28-82		2b. HOUR 7:40 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEB 11, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY WASH.		12b. KIND OF BUSINESS OR INDUSTRY REFRIGERATION			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2606 ELMORA STREET
14. FATHER'S NAME FIRST MIDDLE LAST JULIUS W. HARPER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY W. MULLEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-32-2320		17. INFORMANT ADDRESS SISTER IN LAW 7209 ARROWWOOD ROAD SARA D. BYRNE BETHESDA, MD. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic obstructive Pulm. Disease. DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3.23 , 19 82 to 3.28 , 19 82 , that (I) (we) last saw the deceased alive on 3.28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ratindra K. Sarin MD		DEGREE MD		22c. DATE SIGNED 3/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RATINDRA K. SARIN		22e. ADDRESS 6201 Greenbelt Rd College Park MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/31/82		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	
23d. LOCATION CITY OR TOWN ARLINGTON		COUNTY VIRGINIA		STATE	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR APR 5 1982	
25b. REGISTRAR'S SIGNATURE Francis J. Collins					

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Released by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8 2 0 7 4 6 8				
1. DECEASED NAME (TYPE OR PRINT) <div style="display: flex; justify-content: space-between;">WayneM.Dickerson</div>					2a. DATE OF DEATH MONTH DAY YEAR March 31 82				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 27, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7b. HOUR 8:40 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Estimator		12b. KIND OF BUSINESS OR INDUSTRY Lumber	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4625 Edgefield Road		
14. FATHER'S NAME FIRST MIDDLE LAST Louis Dickerson					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Longbottom				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 225-10-0937				
17. INFORMANT ADDRESS Diane A. Shoemaker, Daughter, 4107 Warner St., Kensington, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST- REPEATED</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>VENTRICULAR IRRITABILITY</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>CORONARY ARTERY DISEASE</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 yrs</u> <u>4 yrs</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>CEREBROVASCULAR DISEASE AND PERIPHERAL VASCULAR DISEASE</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>12/1</u> 19 <u>80</u> , to <u>3/31</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>3/31</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <u>Roger Stevenson, Jr.</u>					DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/31/82</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROGER STEVENSON, JR. MD</u>					22e. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE, MD</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE <u>April 2, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park, Falls Church, VA</u>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</u>					25a. DATE REC'D. BY REGISTRAR <u>APR 5 1982</u>		25b. REGISTRAR'S SIGNATURE <u>James Van Nuthen</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Margaret AGNES DILLE			2a. DATE OF DEATH MONTH 3 DAY 29 YEAR 82 7:37 P.M.		
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH 6 DAY 16 YEAR 1901	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST JOHN MIDDLE JOSEPH LAST KENNEDY			15. MOTHER'S MAIDEN NAME FIRST ROSE MIDDLE MCCORMACK LAST MCCORMACK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-52-5452	17. INFORMANT DAUGHTER ADDRESS 4108 HAVARD STREET SILVER SPRING, MD. 20906		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Atherosclerotic Heart Disease 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) with Congestive Failure.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MINS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 24 February 1982 to 29 March 1982 , that (I) (we) last saw the deceased alive on 29 March 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, state: did not view the body after death)					
22b. SIGNATURE Michael M. Healy MD		DEGREE MD		22c. DATE SIGNED 3/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael M. HEALY, M.D.		22e. ADDRESS 5652 Shields Drive, Bethesda MD 20817			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/1/82	23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR APR 5 1982 25b. REGISTRAR'S SIGNATURE Francis J. Collins		



RECEIVED

NOV 11 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The information obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the certificate must be placed in the container with the body and the container must be sealed. The certificate must be placed in the container with the body and the container must be sealed. The certificate must be placed in the container with the body and the container must be sealed.

signature must be notified at once

29

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 7 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		20. DATE OF DEATH		MONTH DAY YEAR		26. HOUR	
Harold M. Dixon, Sr.				March 1, 1982				7:35 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Male		White		July 13, 1918		63			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Takoma Park		Washington Adventist Hospital		Retired Salesman		Supply Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		P.G.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7201 Claymore Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
James B. Dixon		Ida Lee Hutchison		Yes-Army W.W.II		579-16-0290		Harold M. Dixon, Jr. Harrison, Tenn.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac & Renal Failure</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac & Renal Failure</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac & Renal Failure</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac & Renal Failure</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac & Renal Failure</u>	
4140		4140		4140		4140		4140	
DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic Heart Disease</u>		DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic Heart Disease</u>		DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic Heart Disease</u>		DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic Heart Disease</u>		DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Arteriosclerotic Heart Disease</u>	
35 years		35 years		35 years		35 years		35 years	
DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Arteriosclerosis Generalized</u>		DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Arteriosclerosis Generalized</u>		DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Arteriosclerosis Generalized</u>		DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Arteriosclerosis Generalized</u>		DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Arteriosclerosis Generalized</u>	
45 years		45 years		45 years		45 years		45 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Bilateral below the knee amputations that interfered with exercise.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>Nov. 9, 1980</u> to <u>March 1, 1982</u> , that (I) <u>was</u> saw the deceased alive on <u>Feb. 28, 1982</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> <u>not</u> view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Walcott W. Gibson M.D.</u>						3-1-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Walcott W. GIBSON, M.D.		4300 St. Barnabas Road Marlow Heights, Md. 20748							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		March 4, 1982		Arlington National Cem. Arlington		Arlington Va.			
24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR ADDRESS		24. FUNERAL DIRECTOR PHONE		24. FUNERAL DIRECTOR CITY OR TOWN			
F. Gasch's Sons F.H. P.A. Hyattsville, Md.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

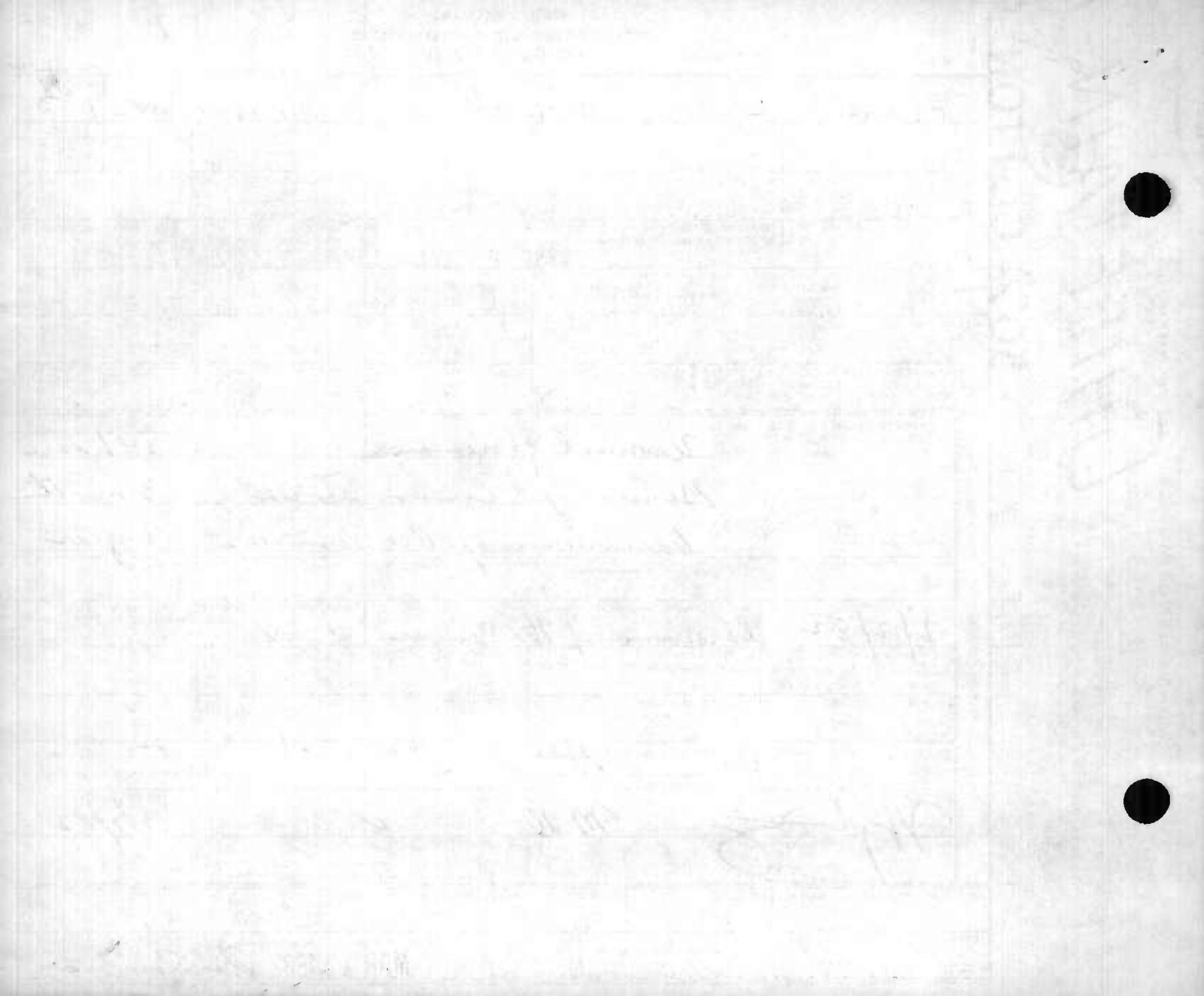
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 0 7 4 7 1					
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD CLAYTON DONLEY					2a. DATE OF DEATH MONTH DAY YEAR March 7, 1982			2b. HOUR MIN 1:40 PM		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 31, 1910		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 71 YRS		7. IF UNDER 1 YEAR IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PBX INSTALLER/REPAIR		12b. KIND OF BUSINESS OR INDUSTRY C & P		
13a. STATE MARYLAND					13b. COUNTY PRINCE GEORGES		13c. CITY OR TOWN ADELPHI		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EDGAR C. DONLEY					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATE RAUDENBUSH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 180-03-3204		17. INFORMANT DAUGHTER		ADDRESS 6908 TENNYSON TERRACE ROCKVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of the Pancreas</u> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 3 months 1 year								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		
19a. DATE OF OPERATION 2/12/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of the Pancreas			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/31, 1982, to 3/1, 1982, that (I) (we) lost saw the deceased alive on 3/2, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23a. SIGNATURE HUGH IREY					DEGREE MD			23b. DATE SIGNED 3/2/82		
23c. PHYSICIAN'S NAME (TYPE OR PRINT) HUGH IREY					23d. ADDRESS SILVER SPRING, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3/10/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D. BY REGISTRAR MAR 12 1982		25b. REGISTRAR'S SIGNATURE Anne J. [Signature]			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph V. Dove			2a. DATE OF DEATH MONTH DAY YEAR 3 26 82		2b. HOUR 3:30 P.M.		
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 6 5 20		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) restaurant		12b. KIND OF BUSINESS OR INDUSTRY owner	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Dove		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lena Checo					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 118-03-9846		17. INFORMANT ADDRESS Laura M. Dove same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 MIN 4 YEARS							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 11125 ROCKVILLE PIKE ROCKVILLE, MD			
22a. I certify that (I) (this hospital) attended the deceased from JULY 19 78 to 3/26 19 82 , that (I) (we) lost 0 8/26 19 82 above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Roger Stevenson, Jr. MD				DEGREE MD		22c. DATE, SIGNED 3/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, JR. MD				22e. ADDRESS 11125 ROCKVILLE PIKE ROCKVILLE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/20/82		23c. NAME OF CEMETERY OR CREMATORY Gate of Haven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland				25a. D. REC'D BY REGISTRAR APR 1 1982		25b. REGISTRAR'S SIGNATURE Thane Janney	

100% 100% 100%

New York

USA

X

Hospital

Government owned

Montgomery Rockville

1201 Aspen Hill Road

Carl

Have

John

Chase

Yes

Yes

100-00-0000

James H. Love name on 100

James H. Love

James H. Love

X

James H. Love

James H. Love

James H. Love

James H. Love

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 21a, only injury, or other traumatic event, the medical examiner must be notified prior to burial.

Cleared by Dr. John G. Ball

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 7 3			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Josephine A. Doyle								March 8 1982					10:09 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
female		white		Oct. 3, 1900		81 YRS		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Massachusetts		USA				Montgomery MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											
Kensington		10906 Jolly Way											
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		Montgomery		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		10906 Jolly Way				retired secretary U.S. Gov't.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
James B. Sweeney		Annie MacClean											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		215 44 8264		Jean A. Zissis		Same as item 13a-e							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CEREBROVASCULAR</u> <u>4370</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 7, 1982</u> to <u>MARCH 8, 1982</u> that (I) (we) lost saw the deceased alive on <u>3-8</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
<u>Richard H. Pollen</u>		MD				3-9-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Richard H. Pollen		10400 Connecticut Ave. Kensington, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		3-12-82		Arlington National		Arlington		Virginia					
24. FUNERAL DIRECTOR		25a. DATE REG'D. BY REGISTRAR											
Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852		MAR 15 1982											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR						20. DATE OF DEATH MONTH DAY YEAR						26. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gaither Leon DRAPER						March 12, 1982						9:25 A_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 18, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY Sales					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 17713 Parkridge Dr.					
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Charles Draper						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beulah Estelle Harne							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-16-4623		17. INFORMANT ADDRESS Mrs. Helen L. Draper Item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1629										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30-40 months months 10 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 55 , to 3-12-82 , 19 82 , that (I) <u>have</u> last saw the deceased alive on 3-10 , 19 82 , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <u>did</u> (did not) view the body after death.													
22b. SIGNATURE Jack Schumacher M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/12/1982			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher, M.D.						22e. ADDRESS 105 Russell Ave., Gaithersburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/15/82		23c. NAME OF CEMETERY OR CREMATORY Clarksburg Ceme.		23d. LOCATION CITY OR TOWN COUNTY STATE Clarksburg Montg. Md.							
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAR 15 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

FOR THE RECORD

WILLIAM



1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 7 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William B. Dunlap, Jr.			2a. DATE OF DEATH MONTH DAY YEAR March 12 1982		2b. HOUR 8:45 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1803 August Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CPA		12b. KIND OF BUSINESS OR INDUSTRY Treasury Dept
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William B. Dunlap, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Eberhardt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 161-03-6591		17. INFORMANT ADDRESS Helen R. Dunlap Wife Same as 13	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, sudden death. 4100 DUE TO, OR AS A CONSEQUENCE OF (b) art-sclerotic - c - v. disease. DUE TO, OR AS A CONSEQUENCE OF (c) Cardiac Arrhythmia S/P Myocardial infarct. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/22/82 to 2/22/82 , that (I) (we) lost saw the deceased alive on 2/22/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death.					
22b. SIGNATURE H. Montakhab		DEGREE MD		22c. DATE SIGNED 3/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. MON T A K H A B. M. D.		22e. ADDRESS 6111 Executive Blvd Rockville MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Mont. Md.		24. FUNERAL DIRECTOR NAME Francis J. Collins ADDRESS 500 University Blvd., W. Silver Spring, Md.			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Francis J. Collins			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4715 1901

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4715 1901

MAR 28 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 4 7 6			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) William H. Earp				March 9, 1982			
3 SEX Male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Mar. 24, 1913		6 AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dry Cleaning Store		12b KIND OF BUSINESS OR INDUSTRY Operator	
13a RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland. Howard. Fulton.				13b INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME George G. Earp				15 MOTHER'S MAIDEN NAME Annie L. Simpson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b SOCIAL SECURITY NO. 214-03-8078		17 INFORMANT ADDRESS Ella Mae Earp (Wife) 13 e			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic vein thrombosis 5733 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Toxic hepatitis (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Mar. 8, 1982, to Mar. 9, 1982, that (I) (we) last saw the deceased alive on Mar. 8, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frederick Moomau, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-9-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick Moomau, M.D.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial.		23b. DATE Mar. 12, 1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION Bladensburg Rd. P. G Co., Md.	
24. FUNERAL DIRECTOR Takoma Funeral Home.				25a. DATE REC'D. BY REGISTRAR MAR 15 1982		25b. REGISTRAR'S SIGNATURE	
254 Carroll St. N. W. D. C.							

No. 214-03-8078 Elia Mae Barn (Wife) 13 e
 George G. Barn
 Annie L. Simpson.
 7131 Pindell School
 Road.
 +
 Dr. Glennie Stone
 Operation
 +
 Mar. 24, 1913
 White.

Burial. Mar. 12, 1982 Ft. Lincoln Gladensburg Mo. P. O.
 Co. Mo.
 Lakona Funeral Home.
 1001 Carroll St. W. D. C.

1244 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1503

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HARRY THEODORE ELDRIDGE			2a. DATE OF DEATH Month MARCH Day 2 Year 1982			2b. HOUR 4:30 AM							
3. SEX MALE		4. RACE CAUCASTAN		5. DATE OF BIRTH JAN 17, 1919		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) MAINE		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY			Md.				
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1106 TIFFANY ROAD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) V.A. ADM.			12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1106 TIFFANY ROAD					
14. FATHER'S NAME First CARL Middle ELDRIDGE Last			15. MOTHER'S MAIDEN NAME First GRACE Middle BARENTZEN Last										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) YES		(If yes give war or dates of service) WW II		16b. SOCIAL SECURITY NO. 006-03-1860		17. INFORMANT Address FREDA W. ELDRIDGE SAME AS 13 WIFE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY HEART DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate Months													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE - BILIARY CIRRHOSIS													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from MARCH, 1981 , to MARCH 1, 1982 , that (I) (we) last saw the deceased alive on MARCH 1, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert B. Irej MD					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED MAR 2, 1982					
22d. PHYSICIAN'S NAME (Type) ROBERT B. IREJ					22e. ADDRESS 11161 New Hampshire Ave, Silver Spring								
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 3/4/82		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY			23d. LOCATION (City or Town) (County) (State) ALEXANDRIA VIRGINIA						
24. FUNERAL DIRECTOR FRANCIS J. COLLINS					ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. REC'D BY REGISTRAR MAR 8 1982		25b. REGISTRAR'S SIGNATURE Ramon J. [Signature]				

UNITED STATES DEPARTMENT OF THE INTERIOR

OFFICE OF THE SECRETARY



WASHINGTON, D. C.

February 1, 1900

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 29th inst.

and in reply to inform you that the same has been forwarded to the

proper authorities for their consideration.

I am, Sir, very respectfully,

Your obedient servant,

John D. Smith

Secretary

Department of the Interior

Washington, D. C.

Very truly yours,

John D. Smith

Secretary

Department of the Interior

Washington, D. C.

Very truly yours,

John D. Smith

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Department of the Interior

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Secretary

THIS DOCUMENT IS NOT TO BE REPRODUCED OR TRANSMITTED IN ANY FORM OR BY ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION STORAGE AND RETRIEVAL SYSTEM.

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IMPORTANT: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) TAMMY MARION ELKINS					2a. DATE OF DEATH MONTH DAY YEAR March 11, 1982			2b. HOUR a 5:15 m			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1959		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HR. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center (NIH)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auctioneer		12b. KIND OF BUSINESS OR INDUSTRY Sales			
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Box 189 21502			
14. FATHER'S NAME FIRST MIDDLE LAST Clarence E Jones					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Jackson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-76-2666		17. INFORMANT ADDRESS Mr. Jesse Elkins (husband) same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Wide Spread Hodgkin's Disease 2019 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (x) (this hospital) attended the deceased from Feb. 22, 1982, to Mar. 11, 1982, that (x) (we) last saw the deceased alive on Mar. 11, 1982, and that in (x) (our) opinion death occurred on the date and hour and from the causes stated above. (x) (we) (did) (not) view the body after death.											
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP D. LEWING, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. ADDRESS The National Institutes of Health Clinical Center, Bethesda, Md, 20205											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar 14, 1982		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR NAME Silcox-Merritt Funeral Service, Cumberland, Md						404 Decatur St ADDRESS		25a. DATE REC'D. BY REGISTRAR MAR 16 1982			
						25b. REGISTRAR'S SIGNATURE Thomas J. [Signature]					

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Jackson.

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Dr. J. A. Jones, Zion Hospital Park

JOHNSON, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 07479	
1. DECEASED NAME (TYPE OR PRINT) Methilda Evans Ellerbrook						2a. DATE OF DEATH MONTH DAY YEAR March 2, 1982				2b. HOUR 4:50 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov 20 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH Johns Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FEDERAL GOVT		12b. KIND OF BUSINESS OR INDUSTRY SAME			
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Johns Park						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8508 SPRINGVALE TERRACE			
14. FATHER'S NAME FIRST THOMAS MIDDLE W. LAST EVANS		15. MOTHER'S MAIDEN NAME FIRST HELEN MIDDLE CAROLINE LAST JOHNSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-50-1728		17. INFORMANT ADDRESS JAMES H. ELLERBROOK, SULLIVAN, ILL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2030 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary hypertension; COPD.											
(c) Multiple Myeloma; C.H.F.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2/27/82 , 19__, to 3/2/82 , 19__, that (I) (we) last saw the deceased alive on 3/2/82 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Miguel A. Rodriguez M.D. DEGREE M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		71c. DATE SIGNED 3/3/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MIGUEL A. RODRIGUEZ						72a. ADDRESS 831 Univ. Blvd. S.S. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.				23b. DATE Mar. 5, 1982		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Rd. P. G. Co. Md.			
24. FUNERAL DIRECTOR Takoma Funeral Home Inc.				25a. DATE REC'D. BY REGISTRAR C. MAR 4 1982		25b. REGISTRAR'S SIGNATURE Ramona J. ...					

254 Carroll St. N. W. D. C.
National General Home Inc.

Mar. 5, 1962 Ft. Lincoln

Bladenburg Md. T. C. Co.

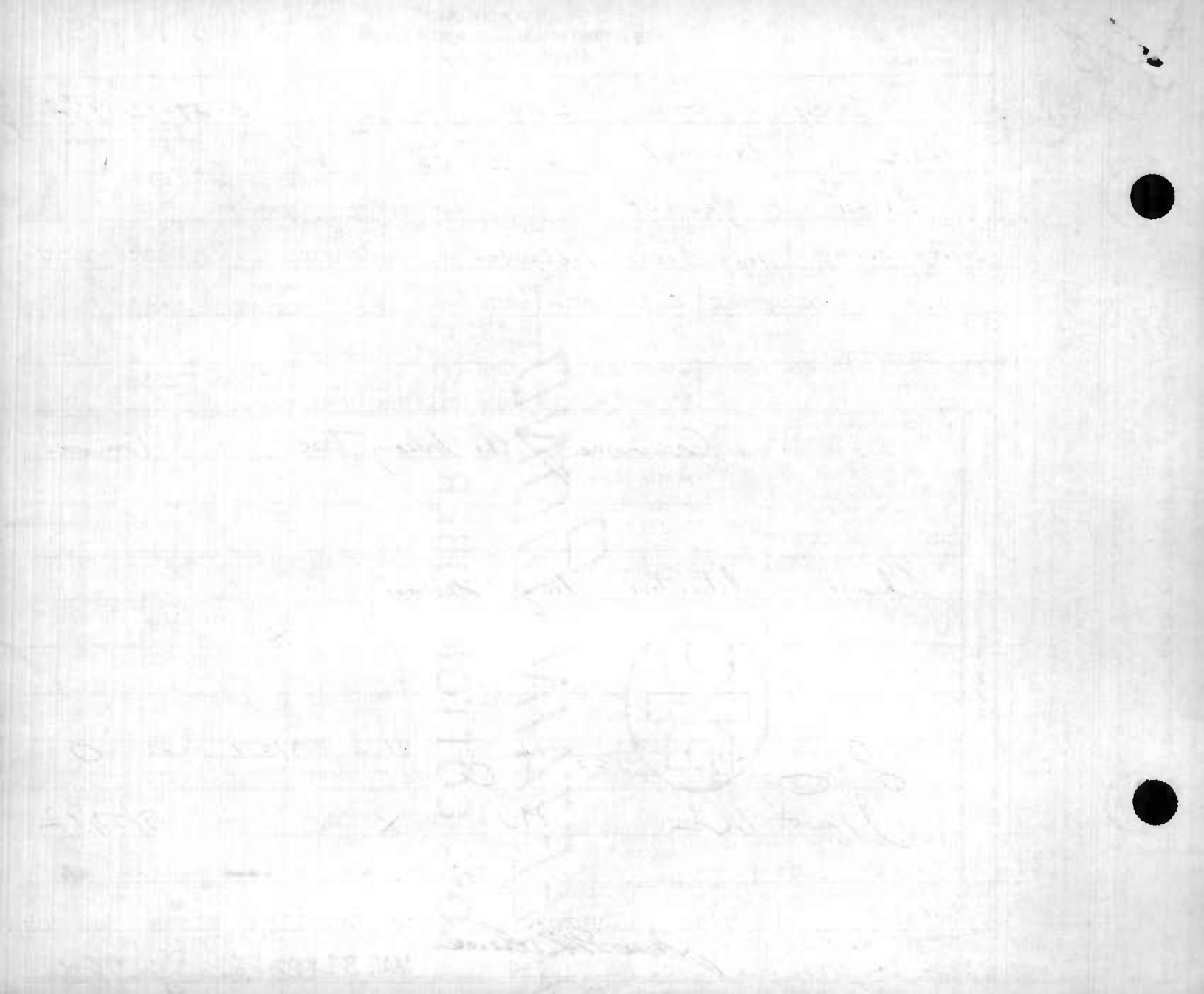
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 8 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Suey G. im Eng</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>3-27-82</i>		2b. HOUR <i>9⁰⁰ A M</i>	
3. SEX <i>Male</i>		4. RACE <i>Oriental</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2-xx-06</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>China</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Yes-USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Owner</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Restaraunt</i>	
13a. STATE <i>Md.</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spr.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Unknown</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Unknown</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>539-28-2239</i>		17. INFORMANT ADDRESS <i>82 Madison Street Kue Wai Eng New York, N. Y.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the biliary tree</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Chronic obstructive lung disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12</i> <i>19 81</i> , to <i>3/27</i> <i>19 82</i> , that (I) (we) last saw the deceased alive on <i>3/26</i> <i>19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Irnest S. Oser</i>				DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3/27/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Irnest S. Oser</i>				22e. ADDRESS <i>10301 Ga. Ave. Silver Spring Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/7/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cypress Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brooklyn Kings New York</i>	
24. FUNERAL DIRECTOR NAME <i>Warner E. Pumphrey Inc.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 31 1982</i>			
24b. ADDRESS <i>8434 Ga. Ave. Sil. Spr. Md. 20910</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Van Natten</i>			



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STATE OF MARYLAND

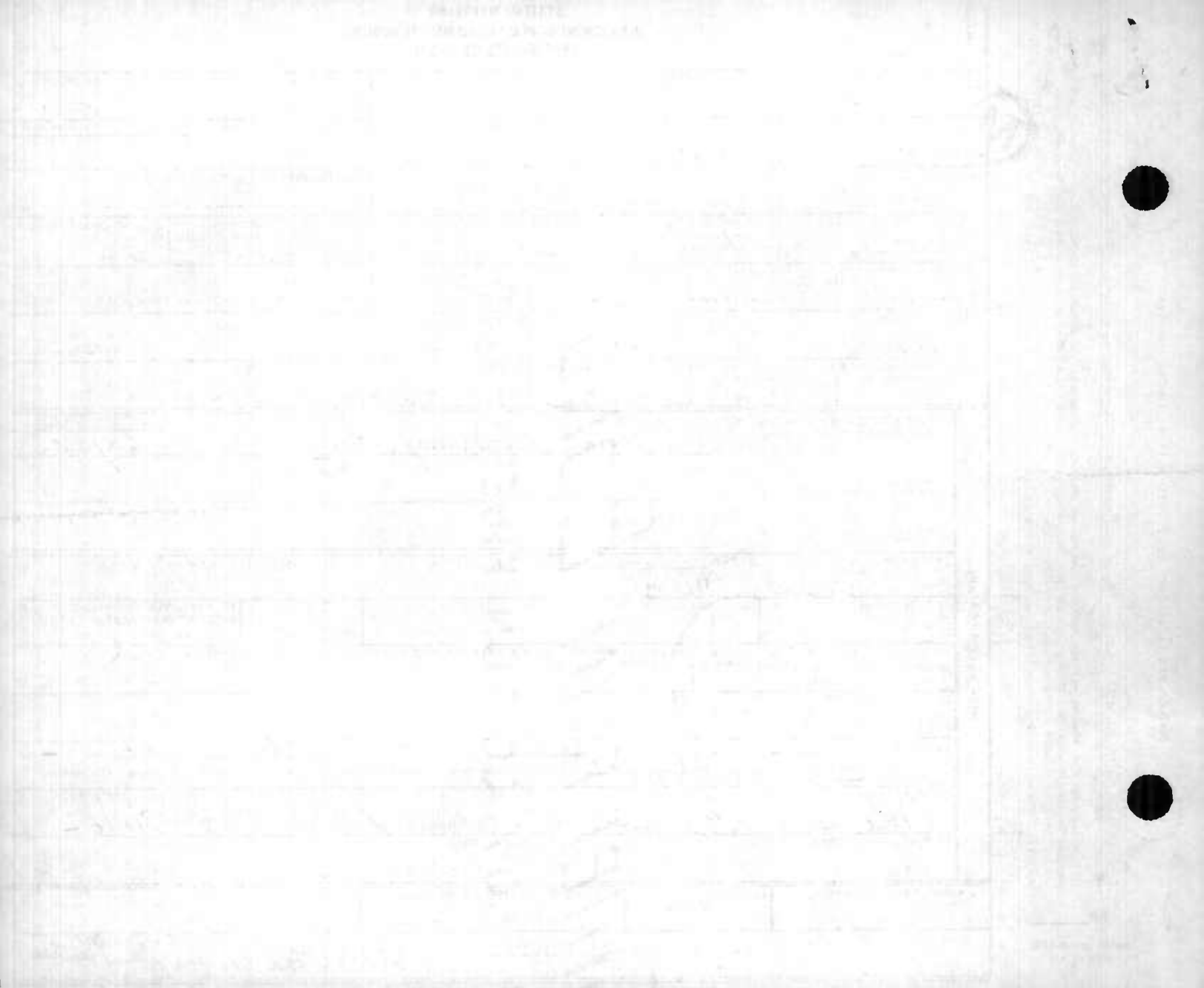
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 4 8 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha C. Engelhard			2a. DATE OF DEATH MONTH DAY YEAR March 10, 1982			2b. HOUR P M 5:30 P	
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR Jan. 8 1895	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa			7b. CITIZEN OF WHAT COUNTRY? United States			8. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6210 Stoneham Road			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Gehringer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Limpke			12b. KIND OF BUSINESS OR INDUSTRY (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker Home	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 502-24-2698			17. INFORMANT Doris Shepherd same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ischemic cardiomyopathy 4/48 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Diabetes Mellitus			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10/15, 1980 to 3/10, 1982, that (I) (we) last saw the deceased alive on 2/6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Michael Emmer MD			DEGREE MD			22c. DATE SIGNED 3/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Emmer			22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Removal			23b. DATE March 13, 1982			23c. NAME OF CEMETERY OR CREMATORY Mohall Cemetery	
24. FUNERAL DIRECTOR'S NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland			23d. LOCATION CITY OR TOWN COUNTY STATE Mohall North Dakota			25a. DATE REC'D. BY REGISTRAR MAR 18 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at 1-800-368-1234.

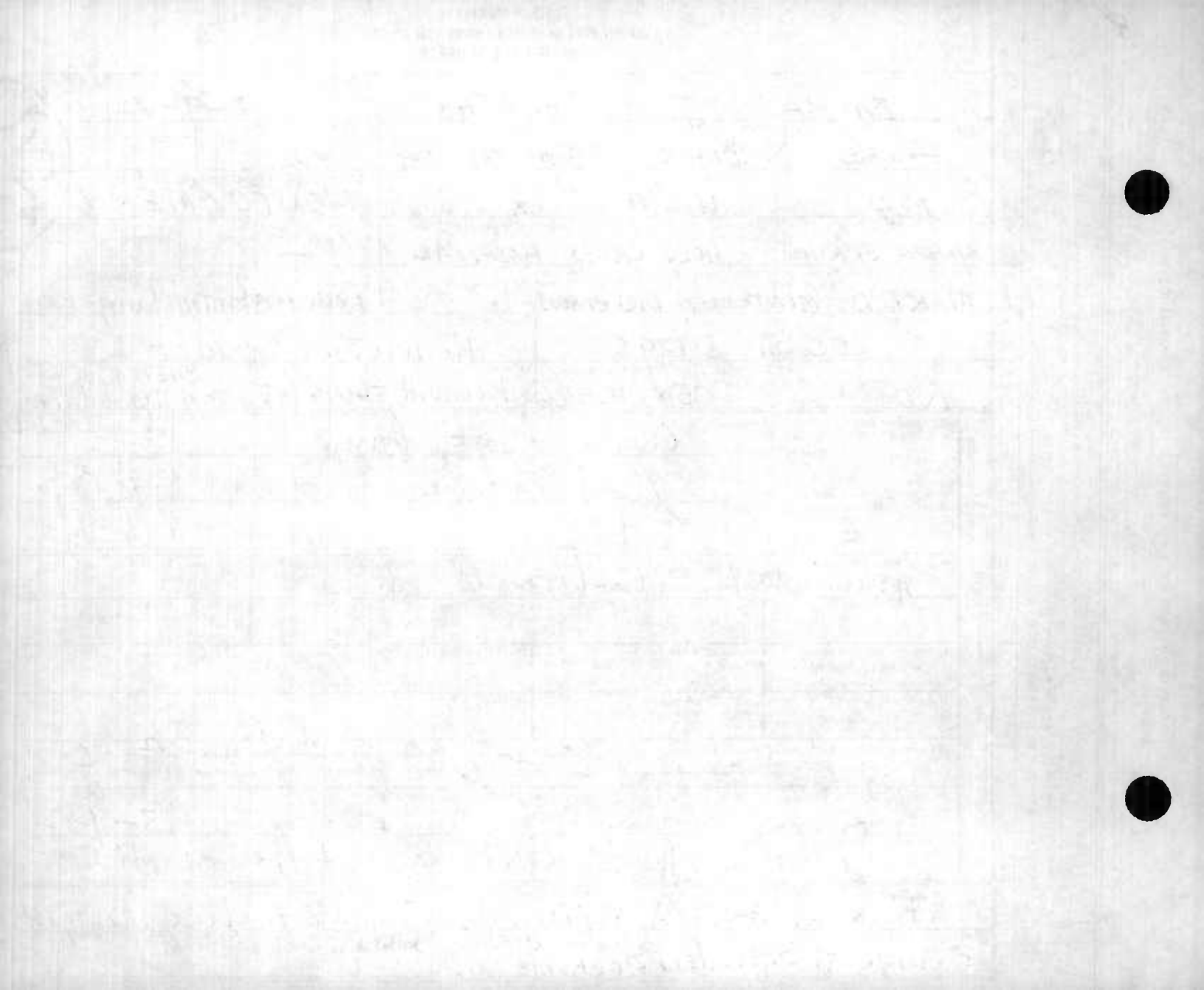
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joyce O. Engle					2a. DATE OF DEATH MONTH DAY YEAR 3/20/82			2b. HOUR 1:45 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 24 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 520 Calvin Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Otjen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST C. Mae Cox				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Leslie Fredrickson-Same as items 13 a-e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF: b) 2000 Congestive Heart Failure c) Diffuse Histiocytic Lymphoma PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypercalcemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 3 month 2 years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from bed 1980 , 19 82 , to 20 March , 19 82 , that (I) (we) last saw the deceased alive on 20 March , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugene P. Libre MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED 3/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE MD					22e. ADDRESS 10400 Conn AVE Kensington, MD 20895				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/21/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR MAR 23 1982		25b. REGISTRAR'S SIGNATURE Frances Jean Nathan		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR			8 2 0 7 4 8 3 REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
EMMA J. FAIRFAX			9-9-82		12:40 AM								
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		BLACK		Sept. 09, 09		72 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
M.D.		U.S.A				MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING		HOLY CROSS HOSPITAL											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLD.		MONTGOMERY		Dickerson		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		102-31 ARROLL Pk.					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Joseph Diggs		Henrietta Stuart											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
NO		518-14-0806		Leonard Payne (Stepson)		3450 Big Wood Hampshire							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer - Lung</u> 0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Renal Failure</u> (c) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 Days 16 Days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atherosclerosis, Cardiovascular disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>March 24</u> , 19 <u>82</u> , to <u>March 9</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>March 18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Benjamin Furman MD</u>		DEGREE		22c. DATE SIGNED									
				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		3-9-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
BENJAMIN FURMAN MD		3720 Farnagut Ave. Ken. Md. 20155											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
BURIAL		3-13-82		Warren Cemetery		Martinsburg Montg Md.							
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25. SIGNATURE OF REGISTRAR		25b. SIGNATURE							
George R. Snowden		246 N. WASH. Rockville, MD.											

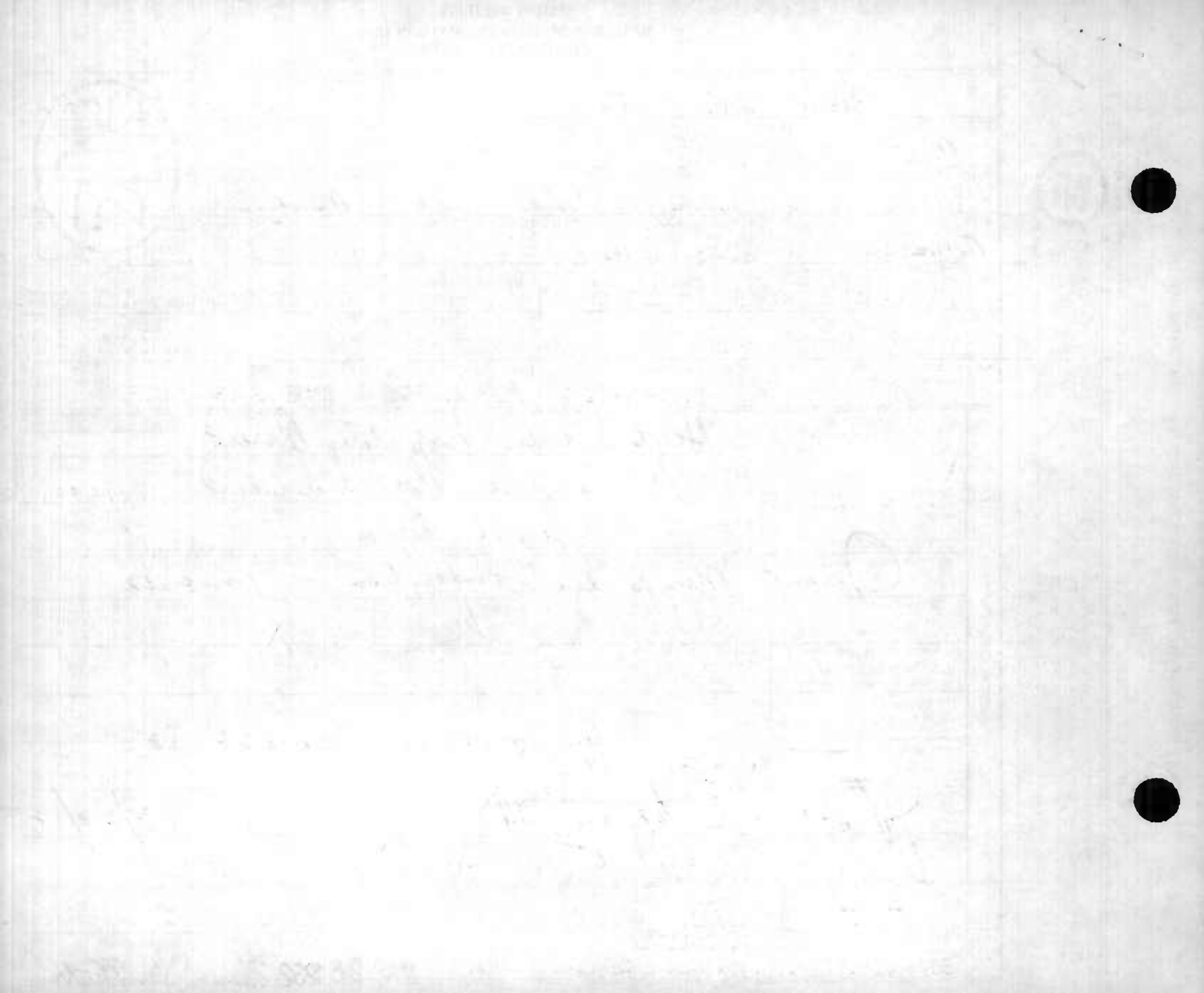


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 0 7 4 8 4				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2b. HOUR				
Alfio W. Faro					3-22-82 11 ²⁰ AM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 24 HRS.	
MALE		CAUCASIAN		FEB 16, 1897		84 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
ITALY		U.S.A.				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hosp.				SHOE MAKER		SELF EMPLOYED	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
MARYLAND			MONTGOMERY		CHEVY CHASE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
JOSEPH FARO					MARIA UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
NO			577-48-1207		JEAN M. FARO			SAME AS 13 WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Cardio Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Open disease</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Recent Myocardial Infarction - 1 month</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) the hospital attended the deceased from <u>August 24 1981</u> to <u>March 22 1982</u> that (2) <u>me</u> last saw the deceased alive on <u>March 21 1982</u> and that in my <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>me</u> did not view the body after death, so state.)									
22b. SIGNATURE <u>J. Blaine Fitzgerald MD</u>					22c. ADDRESS <u>SILVER SPRING MARYLAND</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
J. BLAINE FITZGERALD					SILVER SPRING MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
ENTOMBMENT			3/25/82		GATE OF HEAVEN MAUSOLEUM		SILVER SPRING MONT MD.		
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR				
FRANCIS J. COLLINS					MAR 26 1982				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25b. REGISTRAR'S SIGNATURE <u>James J. Walker</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 8 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy Lansdale Felter				2a. DATE OF DEATH MONTH DAY YEAR 3 11 1982		2b. HOUR 2:AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 MONTH 24 1918		6. AGE (IN YEARS LAST BIRTHDAY) 63	
7a. BIRTHPLACE (STATE OR FOREIGN) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A HOSPITAL, GIVE STREET ADDRESS) 3507 Tarkington Lane,		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistical Clerk		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3507 Tarkington Lane.	
14. FATHER'S NAME FIRST MIDDLE LAST Roger Lansdale				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Fox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS DeWitt C. Felter-husband-(same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of neck, larynx DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic to lungs							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION 3/8/1982		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer in neck		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) Allen Small, MD attended the deceased from 8-21 19 1978 to 3-11 19 82 , that (I) xx last saw the deceased alive on 3-9 19 82 , and that in (my) xx opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d) (did) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-11-1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen Small, MD				22e. ADDRESS 1234 19th. Street, N.W. Washington, DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3-15-1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sil. Spring Montgomery Md.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAR 18 1982		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) ELLA - FERGUSON					2a. DATE OF DEATH MONTH 03 DAY 30 YEAR 82			2b. HOUR 2:15A		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 07 DAY 10 YEAR 88		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bavaria		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE md.					13b. COUNTY Howard		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST William MIDDLE LAST Koestler					15. MOTHER'S MAIDEN NAME FIRST Anna MIDDLE LAST Schmidt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 214035944		17. INFORMANT John Ferguson, -3rd- above			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary and Cerebrovascular Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/25 , 19 82 , to 3/30 , 19 82 , that (I) (we) last saw the deceased alive on 3/25 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we did not) view the body after death.										
22b. SIGNATURE Robert Millman MD						DEGREE		22c. DATE SIGNED 3/30/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman, MD						22e. ADDRESS 15 E Deer Park Dr Gaithersburg MD 20877				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Mar. 31, 1982		23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Park		23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A. ADDRESS Damascus, Md.										

12

12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/76
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO. 8 2 0 7 4 8 7							
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Teresa Finley					2a DATE OF DEATH MONTH DAY YEAR March 12, 1982			2b HOUR 8:30AM	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1980		6 AGE (IN YEARS LAST BIRTHDAY) 101 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10 CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 4213 Oak Ridge Lane	
14 FATHER'S NAME FIRST MIDDLE LAST John Smith					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Coburn				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 496 30 9725		17 INFORMANT Daughter Mrs. Alban Leyes Same as item 13					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 yrs.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/6</u> , 19 <u>77</u> , to <u>Mar 12</u> , 19 <u>82</u> , that (we) lost saw the deceased alive on <u>3/12/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Marvin Waddler</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED March 12, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin Waddler, M.D.				22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 13, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR MAR 18 1982		25b. REGISTRAR'S SIGNATURE <u>James J. Nathan</u>			

BP

(17)

CONFIDENTIAL

MEMORANDUM FOR THE RECORD

SUBJECT: [Illegible]

DATE: [Illegible]

BY: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

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96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) EILEEN MARGARET FISKE					2a. DATE OF DEATH MONTH DAY YEAR MARCH 26, 1982					2b. HOUR 9:40 a.m.
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 28, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CHINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C.					13b. CITY OR TOWN D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS WASHINGTON, D.C. 20007	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR JAMES SAUNDERS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMY ESDALE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT unknown		17. ADDRESS 110 Bath ST., OAKVILLE DOREEN BOTTERELL: ONTARIO, CANADA L6J582				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) WIDELY METASTATIC CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (b) COMPLICATED BY PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1579										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>19 MARCH</u> , 19 <u>82</u> , to <u>26 MARCH</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>26 MARCH</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Pamela A. Karies						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 27 MARCH 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. KARIES, CDR, MC, USN						22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.				
23a. BURIAL, CREMATION, REMOVAL CREMATION			23b. DATE MARCH 29, 1982		23c. NAME OF CEMETERY OR CREMATORY METROPLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS Homes, P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE James Van Natten		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) RUSSELL ASHBY FITZWATER RUSSELL A. FITZWATER					2a. DATE OF DEATH MONTH DAY YEAR MARCH 31 20 82			2b. HOUR 2325 M			
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR JULY 26 96		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) WEST VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (TYPE OR PRINT) (STREET ADDRESS) SHADY GROVE ADV. HOSPITAL				12a. USUAL OCCUPATION (TYPE OR PRINT) (MOST OF WORKING LIFE) MAINT.		12b. KIND OF BUSINESS OR INDUSTRY ROAD DEPT.			
13a. STATE MD					13b. COUNTY MONT.		13c. CITY OR TOWN BOYDS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME UNKNOWN MIDDLE LAST					15. MOTHER'S MAIDEN NAME LOVTELLA MIDDLE FITZWATER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-24-6125		17. INFORMANT ADDRESS BEULAH M. FITZWATER SAME AS #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. HYPERTENSION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3 20 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from NOV 81 to FEB 82 , that (I) (we) last saw the deceased alive on FEB 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.											
22b. SIGNATURE Asuncion, Hector C.			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/21/1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASUNCION, HECTOR C.			22e. ADDRESS 20010 FISHER AVE., POKESVILLE MD 20837								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE MARCH 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Flower Hill		23d. LOCATION Redland Mont. County Md. STATE				
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER ADDRESS LAYTONSVILLE MD. 20879			25a. DATE REC'D. BY REGISTRAR MAR 26 1982		25b. REGISTRAR'S SIGNATURE Francis H. Barber						

Cardiovascular Disease
Hypertension

Hypertension

2 20 25

25 20 15 10 5 0

3/1/1952
2000 Fisher Ave., Fort Worth, Texas
Agington, Hector C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
		Morris Flax				March 4, 1982				8:25p M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS	
Male		White		June 23, 1896		85 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Russia		USA				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		Collingswood Nursing Home				Surveyor (Ret)		Surveying			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
Maryland Montgomery						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7420 Westlake Terrace			
14 FATHER'S NAME						15 MOTHER'S MAIDEN NAME					
Jacob Flax						Goldie (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS			
No						220-44-7241		Bethesda, Md. Frances Rubin; 7420 Westlake Terrace			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) UREMIA										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1539 DUE TO, OR AS A CONSEQUENCE OF (b) COLONIC CANCER										5 YEARS	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5-26 1981 to 3-4 1982, that (I) (we) last saw the deceased alive on 3-4 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Walter E. Goozh, M.D.										3-5-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
Walter E. Goozh, M.D.						2309 Shorefield Road, Wheaton, Md. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
Burial				3-7-82		King David Mem. Garden		Falls Church, Va.			
24 FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels; 1170 Rockville Pike						Rockville, Md.		MAR 10 1982			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 9 1	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) MINNIE FLEISHER					2a. DATE OF DEATH MONTH DAY YEAR March 3 82			2b. HOUR 5 am			
3. SEX FEMALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR March 7, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -----			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 410 Lamberton Drive			
14. FATHER'S NAME FIRST MIDDLE LAST Isaac Dickman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Feiler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 089-09-0593A		17. INFORMANT ADDRESS Maryland Isaac Dickman; 410 Lamberton Dr; Silver Spring							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c) M-I ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: -----											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/10/82 to 3/3/82 , that (I) (we) lost saw the deceased alive on 3/3/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE H.D. Khianey		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/3/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HIRSH D KHIANEY				22e. ADDRESS 6121 Montrose Rd, Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/5/82		23c. NAME OF CEMETERY OR CREMATORY Montefiore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Albans New York		23e. DATE REC'D. BY REGISTRAR MAR 8 1982			
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS NAME ADDRESS 1170 Rockville Pike-Rockville, Maryland											
25a. REGISTRAR'S SIGNATURE James J. Mast...											



March 2, 1902

Friday

March

March 2, 1902

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March 2, 1902

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH			MONTH DAY YEAR			2d. HOUR			
Lewis Eugene Ford						3 1 19 82						M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
male		white		July 27, 1950		31 YRS.						3 1 19 82		10:00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			AM MD			
Washington DC			USA						Montgomery County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda			4905 Hampden Lane			Parts Manager Washington Volvo									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Md.			Montgomery			Bethesda			YES <input type="checkbox"/> NO <input type="checkbox"/>			4905 Hampden Lane			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Altus Ford			Betty Ann Rye												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			20814			
no			579-64-4440			Nancy Ford, 4905 Hampden La., Bethesda, Md									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Asphyxia from hanging by neck															
9530															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?						
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			? xx. 3/1 19 82			found hanging									
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			basement/home			4905 Hampden Lane, Bethesda, Montgomery Co., MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> (partial) <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE			TITLE (SPECIFY)						DATE SIGNED						
Hormez R. Guard			M.D. Assistant MEDICAL EXAMINER						3/1/82						
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS												
Hormez R. Guard, M.D.			111 Penn Street, Balto., MD 21201												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION						
burial			3-4-82			Monocacy Cemetery			Beallsville, Md.						
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE						
NAME ADDRESS			MAR 12 1982						Hormez R. Guard						
Everly-Wheatley Funeral Home, Alexandria, Va.															

THE COLLEGE OF THE SOUTHERN CROSS

UNIVERSITY AVENUE

1000

DALLAS, TEXAS 75201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 4 9 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Le <u>Nora</u> <u>B</u> <u>FORTYUNE</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>March 27 1982</u> 2b. HOUR <u>11 AM</u>			
3. SEX <u>FEMALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Nov. 19 1912</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>70</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Sylvan Manor Nursing Home</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Bob</u> <u>Richards</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>LeNors</u> <u>Saw</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>no</u> <u>--</u>			
16a. SOCIAL SECURITY NO. <u>577-34-3730</u>		17. INFORMANT ADDRESS <u>Antoinette Cohill-dau Millersville, Md. 21108</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer - Respiratory System</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>February 23 1982</u> to <u>March 27 1982</u> that (I) (we) lost saw the deceased alive on <u>March 11 1982</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B. Hines</u>				DEGREE		22c. DATE SIGNED <u>3-28-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. Hines</u>				22e. ADDRESS <u>3720 Fairview Ave. N. H. Md 20851</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Apr. 1, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Brentwood</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Pr. Georges Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi Funeral Home</u>				25a. DATE REC'D. BY REGISTRAR <u>MAR 30 1982</u>			
25b. REGISTRAR'S SIGNATURE <u>James J. Nathan</u>							

14 NOV 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 4 9 4	
1. DECEASED NAME (TYPE OR PRINT) FIRST JOHN E. LAST FOXWELL JOHN E. FOXWELL			2a. DATE OF DEATH MONTH DAY YEAR MARCH 2.82		2b. HOUR 10:10A
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 10 1 1907	6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (ITY OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Mont. 13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 125 Charles St.		
14. FATHER'S NAME FIRST Edwin MIDDLE Foxwell			15. MOTHER'S MAIDEN NAME Sarah MIDDLE Pruitt LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes	16b. SOCIAL SECURITY NO. (IF IN U.S. WAR OR DATES) WWII 213-10-7812	17. INFORMANT ADDRESS Edith M. Foxwell Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (b), (c), and (d).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole 4149 DUE TO, OR AS A CONSEQUENCE OF Cardogenic Shock (b) DUE TO, OR AS A CONSEQUENCE OF Coronary artery disease (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES 15-20 Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 2-26-82, 1982, to 3-2-82, 1982, that (1) (we) lost saw the deceased alive on 3-1-82, 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Samuel J. P. Coitt		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL J. COITT		22e. ADDRESS 5632 SHIELDS DRIVE, BETHESDA			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 5, 1982	23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT. MD.	
24. FUNERAL DIRECTOR FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR MAR 8 1982	

REPORT OF THE
COMMISSIONER OF PLANT INDUSTRY
FOR THE YEAR 1907

Presented to the Senate and House of Representatives
at their respective sessions, January 14, 1908

BY
J. H. COOPER, Commissioner

WASHINGTON: GOVERNMENT PRINTING OFFICE
1908

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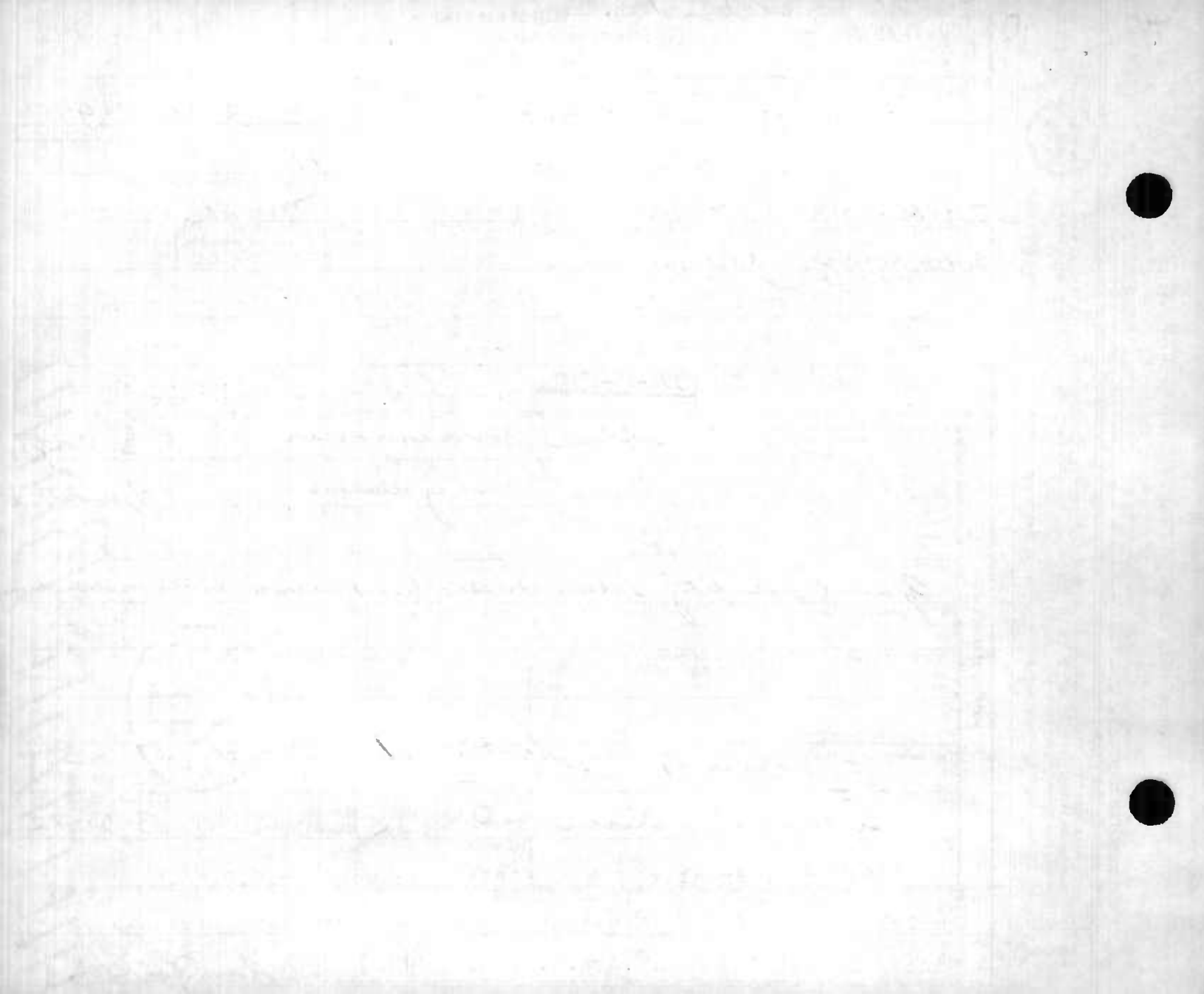
Permit No. 100

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST L. Hubert Frazier										2a. DATE OF DEATH MONTH DAY YEAR 3-30-82		2b. HOUR 9:15 P	
3. SEX M.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 10 21 1900		6. AGE (IN YEARS LAST BIRTHDAY) YRS 81		7. IF UNDER 1 YEAR MONTHS DAYS 81		7b. IF UNDER 24 HRS. HOURS MIN. 81			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Village				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bank Teller		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1307 Leister Drive					
14. FATHER'S NAME FIRST MIDDLE LAST James Frazier					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Fike								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None					16b. SOCIAL SECURITY NO. 291-16-1880		17. INFORMANT ADDRESS Barbara A. Howard (Daughter) Same as above						
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (b)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia 5-188 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) chronic pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) 4 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) General debility, arteriosclerotic heart disease cerebral vascular disease													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Sept 30 19 81 to Mar 30 19 82 , that (I) (we) last saw the deceased alive on Mar 29 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Arthur S. Bresler MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3-30-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur S. Bresler					22e. ADDRESS 10881 Lockwood Dr. S.S.Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/5/82		23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Milwaukee Wisconsin							
24. FUNERAL DIRECTOR NAME Hines/Rinaldi					ADDRESS 11800 N.H.Ave. S.S.Md.		25a. DATE REC'D. BY REGISTRAR APR 1 1982					25b. REGISTRAR'S SIGNATURE James J. Hines	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH-17
(VRA 15 ME (1))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		3. MONTH	
DONALD L. FRIDELL								11		82	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
Male		White		DEC 19 32 49		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		Contractor		Self-Employed					
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Maryland		Prince George		Adelphi		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		70500 Edgemont Drive			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Lee		Bernice		No		578-42-7625		Wife		same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
PART I DEATH WAS CAUSED BY:						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>4149</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Essential Hypertension & Diabetes</u>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:					
		P.M. 19				Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
ACTUAL SIGNATURE <u>Richard S. Helton</u>		EXAMINER'S NAME (TYPE OR PRINT) <u>RICHARD S. HELTON</u>		ADDRESS <u>7100 Balt Ave</u>		DATE SIGNED <u>3-12-82</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		Mar. 13, 1982		Metropolitan		Alexandria Virginia					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Francis J. Collins		MAR 22 1982		Francis J. Collins							
500 University Blvd., W. Silver Spring, Md.											



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Items #16a-22a Film G567 5/L/82 re STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. DATE OF BIRTH			4. AGE (IN YEARS)			5. IF UNDER 1 YR.			6. IF UNDER 24 HRS.			7. DATE PRONOUNCED DEAD			8. BALTIMORE CITY OR COUNTY OF DEATH								
FIRST Conrad			MIDDLE Cody			LAST Fridley			MONTH June			DAY 28			YEAR 1908			MONTH 3			DAY 29			YEAR 1982					
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH June			6. AGE (IN YEARS) LAST BIRTHDAY 73 YRS.			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			9. DATE PRONOUNCED DEAD MONTH 3			DAY 29			YEAR 1982					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			10. CITY OR TOWN OF DEATH Rockville,			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Delicatessen Prop.			12b. KIND OF BUSINESS OR INDUSTRY Retail Store								
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Rockville,			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 409 Cedar Lane,			14. FATHER'S NAME FIRST Perry			15. MOTHER'S MAIDEN NAME FIRST Martha			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			17. SOCIAL SECURITY NO. 236-28-0316			18. INFORMANT Mrs. Nellie G. Fridley, 409 Cedar Lane,		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 3/28/82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject fell			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET McCullough Rd. Rockville Montg. Co. Md.					
22a. I certify that I took charge of the remains described above, held on death resulted from natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. DATE 4/2/82			22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.			22d. LOCATION CITY OR TOWN Fort Ashby, Mineral W. Va.			24. FUNERAL DIRECTOR NAME H. Wayne George 202 Greene St. Cumberland, Md.			25a. DATE REC'D. BY REGISTRAR APR 6 1982			25b. DATE REC'D. BY REGISTRAR APR 6 1982											

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Fractured neck
 8880
 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.
 (b) _____
 DUE TO, OR AS A CONSEQUENCE OF
 (c) _____
 DUE TO, OR AS A CONSEQUENCE OF

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
? P.M. 3/28/82

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Subject fell

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☒ AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
street

21f. LOCATION
STREET
McCullough Rd. Rockville Montg. Co. Md.

22a. I certify that I took charge of the remains described above, held on death resulted from natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

TITLE (SPECIFY)
M.D. Deputy Chief, MEDICAL EXAMINER

DATE SIGNED 3/30/82

EXAMINER'S NAME (TYPE OR PRINT)

Thomas D. Smith, M.D.

ADDRESS 111 Penn ST. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial

23b. DATE
4/2/82

23c. NAME OF CEMETERY OR CREMATORY
Fort Ashby Cem.

23d. LOCATION
CITY OR TOWN
Fort Ashby, Mineral W. Va.

24. FUNERAL DIRECTOR

ADDRESS

H. Wayne George 202 Greene St. Cumberland, Md.

25a. DATE REC'D. BY REGISTRAR

APR 6 1982

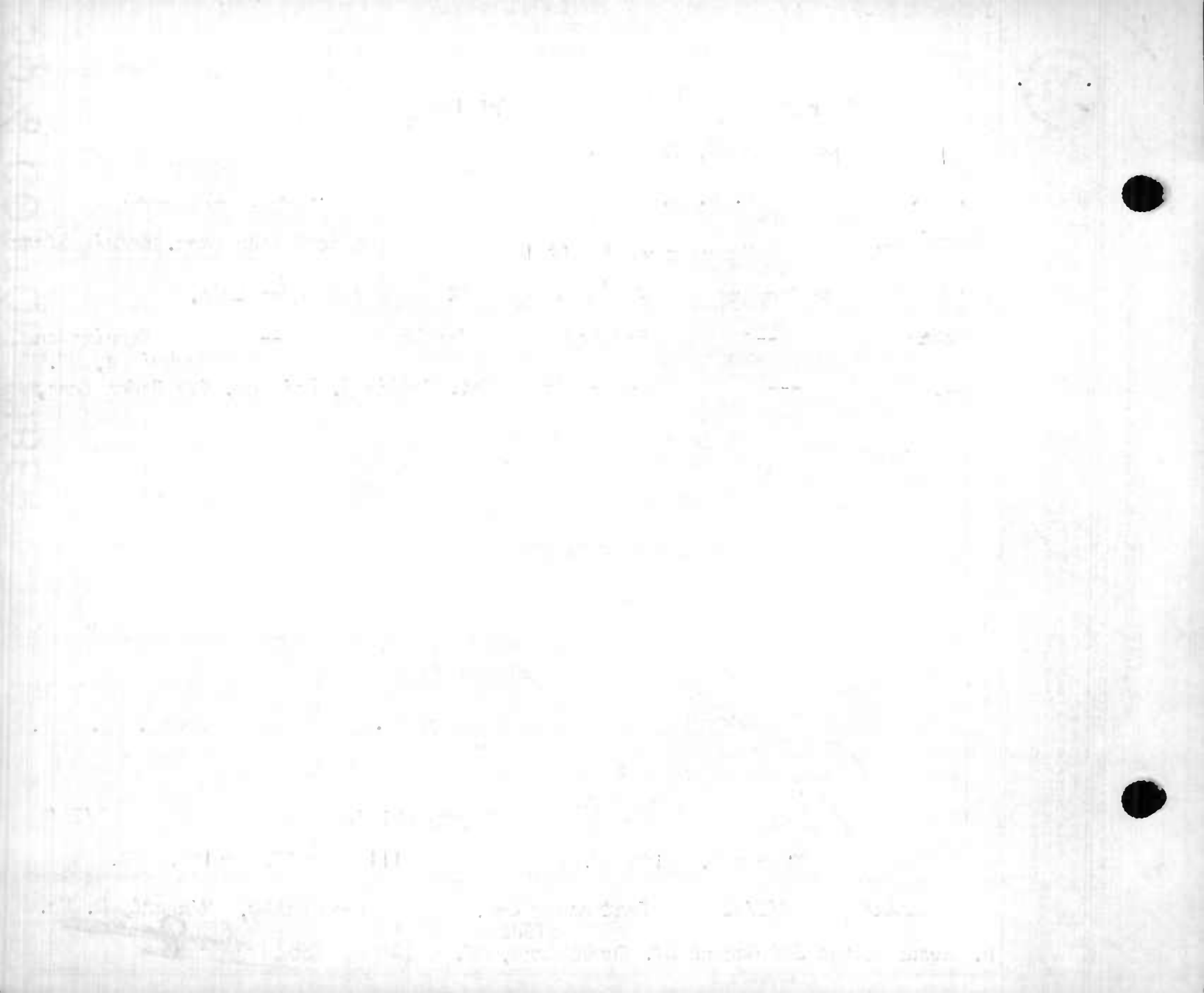
25b. DATE REC'D. BY REGISTRAR

APR 6 1982

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 (VR A15 ME (1)) 15M 2/80



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 4 9 8	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Grey Harman Froelich					2a. DATE OF DEATH March 7, 1982			2b. HOUR 3:15p M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH August 13, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9816 Watts Branch Drive 20850			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur F. Harman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Henderson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 231-36-5383		17 INFORMANT ADDRESS Richard Froelich (husband) same					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Hepato-renal failure DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic adenocarcinoma of colon									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days weeks months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 1/11/82 2/7/82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small bowel volvulus - trach				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 3, 1982 , to March 7, 1982 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on March 7, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated.											
22b. SIGNATURE C. M. Weiss MD					DEGREE MD			22c. DATE SIGNED 3/8/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. M. Weiss MD					22e. ADDRESS National Institutes of Health NIH Clinical Center, Bethesda, Md. 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE March 10, '82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG MD			
24. FUNERAL DIRECTOR NAME Froelich family					DATE REC'D. BY REGISTRAR MAR 12 1982						



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Handwritten notes or signatures in the bottom right corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8 2 0 7 4 9 9				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MRS. ILONA None GALAMBOS.					2a. DATE OF DEATH MONTH DAY YEAR 3 19 1982 2b. HOUR 3:20 A M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR AUG 17 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. UNDER 1 YEAR MONTHS DAYS 7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY		7b. CITIZEN OF WHAT COUNTRY? PERM. RES.-U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY SAME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY MONT 13c. CITY OR TOWN SILVER SPR.					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13 SUNNYSIDE ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST NOT AVAILABLE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BARANYI				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 573-86-3582		17. INFORMANT ADDRESS MARIA E LEMART 13 SUNNYSIDE RD					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. PARIETAL TUMOR, DIABETES, GANGRENE FEET									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-1 19 82 to 3-19 19 82 that (I) (we) last saw the deceased alive on 3-18 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE M SNOW MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M SNOW MD					22e. ADDRESS 9013 FLOWER AVE SILVER SPRING MD 20901				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 22, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem		23d. LOCATION (CITY OR TOWN) Silver Spring		COUNTY MD STATE 20901	
24. FUNERAL DIRECTOR NAME Takoma Funeral Home 841 Madison ADDRESS 2815 Cambridge Ave					25a. DATE REC'D BY REGISTRAR MAR 23 1982		25b. REGISTRAR'S SIGNATURE Frances Jan Nathan		

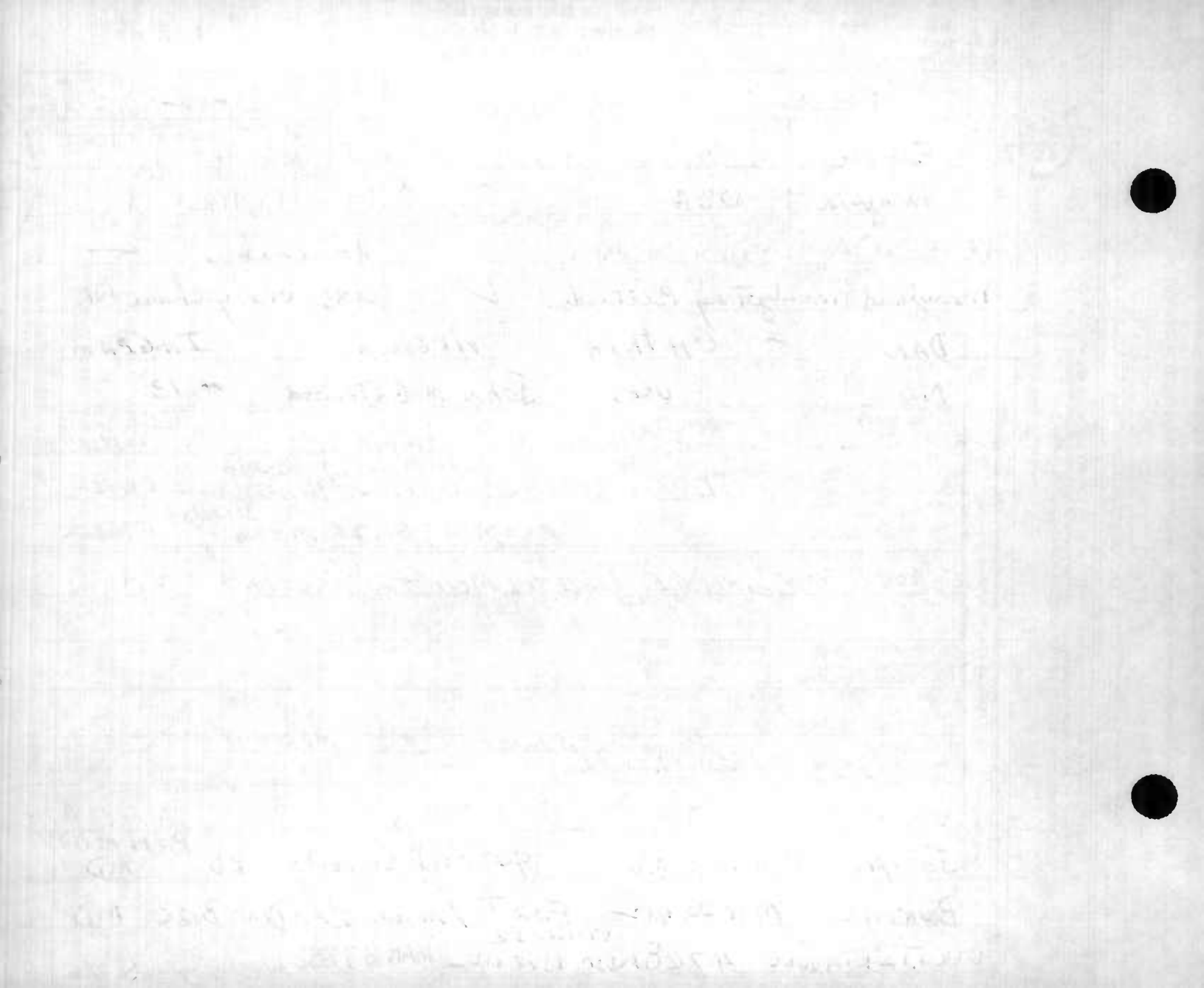
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 5 0 0			
1- STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) BELLE GATEWOOD				2a. DATE OF DEATH MONTH DAY YEAR 3-18-82 2b. HOUR 2:26 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5/20/01		6. AGE (IN YEARS LAST BIRTHDAY) 80 yrs. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST DAN — Cathia				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA INGRAM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. UNK.		17. INFORMANT ADDRESS John M. Gatewood #13			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST 2859 DUE TO, OR AS A CONSEQUENCE OF PULMONARY EDEMA PLEURAL EFFUSIONS; CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF ANEMIA; GASTRO-INTESTINAL BLEEDING APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MINS. 3 WEEKS 5 WEEKS							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC BRAIN SYNDROME; DIABETES MELLITUS; RECENT CVA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 1980 to MARCH 18 1982 , that (I) was last saw the deceased alive on MARCH 17 1982 and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE Joseph Connor, M.D.				DEGREE M.D.		22c. DATE SIGNED MARCH 18 1982	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph CONNOR, MD				22c. ADDRESS 9420 OLD GEORGETOWN RD BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR. 20, 1982		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BLADENBURG MD	
24. FUNERAL DIRECTOR NAME ADDRESS W.W. TALIAVALL 4748 Wisc. Ave NW WASH. DC				25a. DATE REC'D. BY REGISTRAR MAR 23 1982 25b. REGISTRAR'S SIGNATURE Charles J. Nathan			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

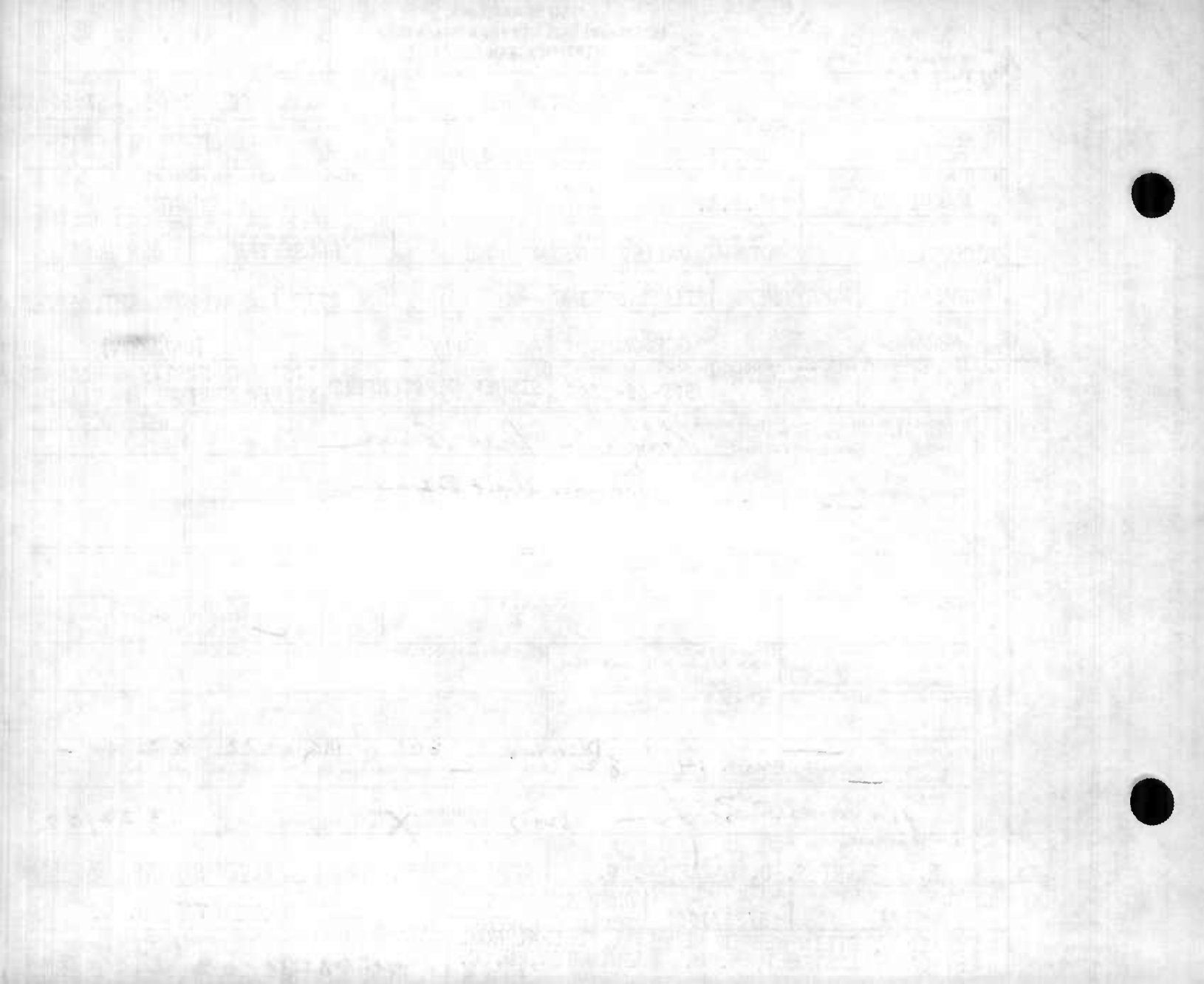
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 5 0 1			
1 - STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) MINNIE G. GERSTENFELD					2a. DATE OF DEATH MARCH 22, 1982				2b. HOUR 7:30 A.M.				
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH DECEMBER 4, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.							
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME					
13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8715 1st AVENUE, APT. 531-C			
14 FATHER'S NAME ABRAHAM				15. MOTHER'S MAIDEN NAME MOLLY (UNKNOWN)		16. ADDRESS 1131 UNIVERSITY BOULEVARD, WEST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 578-62-2803		17 INFORMANT SIDNEY GERSTENFELD, SILVER SPRING, MARYLAND							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ischemic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>December 1980</u> , to <u>March 22, 1982</u> , that (I) (we) lost saw the deceased alive on <u>March 14, 1982</u> , and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <u>Herbert S. Baraf</u>				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/22/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HERBERT S. B. BARAF, M. D.				22e. ADDRESS 8750 GEORGIA AVENUE, SILVER SPRING, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 3/23/1982		23c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM TALMUD TORAH CONGREGATION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D. C.					
24. FUNERAL DIRECTOR OR DECATAL MR. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR MAR 24 1982		25b. REGISTRAR'S SIGNATURE <u>James Van Natten</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 7 5 0 2				
1. FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
RALPH						GIARRATANA		3-13-82					10:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.				
Male		Caucasian		Nov. 23, 1905		76 YRS.		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Italy		U.S.A.				MONTGOMERY CO. MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												
BETHESDA		SUBURBAN HOSPITAL												
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY												
Retired		Barber												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Mass.		Middlesex		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		135 Magazine St.						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
Angelo				Giarratana				Liboria				Andolino		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS		
No				030-26-9327				wife				same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Coronary Perforation Aneurysm</u>													<u>1 hour</u>	
4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia + Chronic Respiratory Failure</u>													<u>10 days</u>	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Alcohol Poisoning</u>													<u>15 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerosis and Disease</u>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR										
				P.M. 19										
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> , 19 <u>82</u> , to <u>3-13</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>3-13</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE				DEGREE				22c. DATE SIGNED						
<u>William H. Killax</u>								3-14-82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS										
William H. Killax				8218 Wisconsin Av BETHESDA										
23a. BURIAL, CREMATION, REMOVAL				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION		
Burial				Mar. 18, 1982				Cambridge Cemetery				Cambridge, Mass.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
NAME				ADDRESS										
Capitol Funeral Service, Fairfax, Va.				MAR 17 1982										

Capital Federal Service, Fairfax, Va.
April 10, 1961
Cambridge Cemetery, Cambridge, Mass.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Esther Exxxxx					2a. DATE OF DEATH MONTH DAY YEAR 03 04 82				
3. SEX Female					2b. HOUR 145 M				
4. RACE White					6. AGE (IN YEARS LAST BIRTHDAY) 65 yrs				
5. DATE OF BIRTH MONTH DAY YEAR 4 19 16					7. IF UNDER 1 YEAR MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska					7b. CITIZEN OF WHAT COUNTRY? America				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County				
10. CITY OR TOWN OF DEATH Silver Spring					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF PREVIOUS YEAR) Retired Metal Bookkeeper					12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD.					13b. COUNTY Mont.				
13c. CITY OR TOWN Silver Spring					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS 11215 Oakleaf Dr.									
14. FATHER'S NAME FIRST MIDDLE LAST Unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 579-20-6125				
17. INFORMANT ADDRESS 11215 Oakleaf Dr.					17. INFORMANT Louis H. Giersch Sil. Spr., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute lymphosarcoma DUE TO, OR AS A CONSEQUENCE OF (b) 5001 DUE TO, OR AS A CONSEQUENCE OF (c) 1 wk									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Pneumonia, Alzheimer's Disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/4 19 82, to 3/4 19 82, that (I) (we) last saw the deceased on 3/4 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) did not view the body after death.									
22b. SIGNATURE Barry N. Rosenbaum, M.D.					DEGREE		22c. DATE SIGNED 3/4/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM					22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20795				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 3/5/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.		
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc.					P.O. Box 7428 Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE James San Nathan		



MAR 8 1982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 5 0 4

FOR
1. STATE
REGISTRAR

REG. NO.

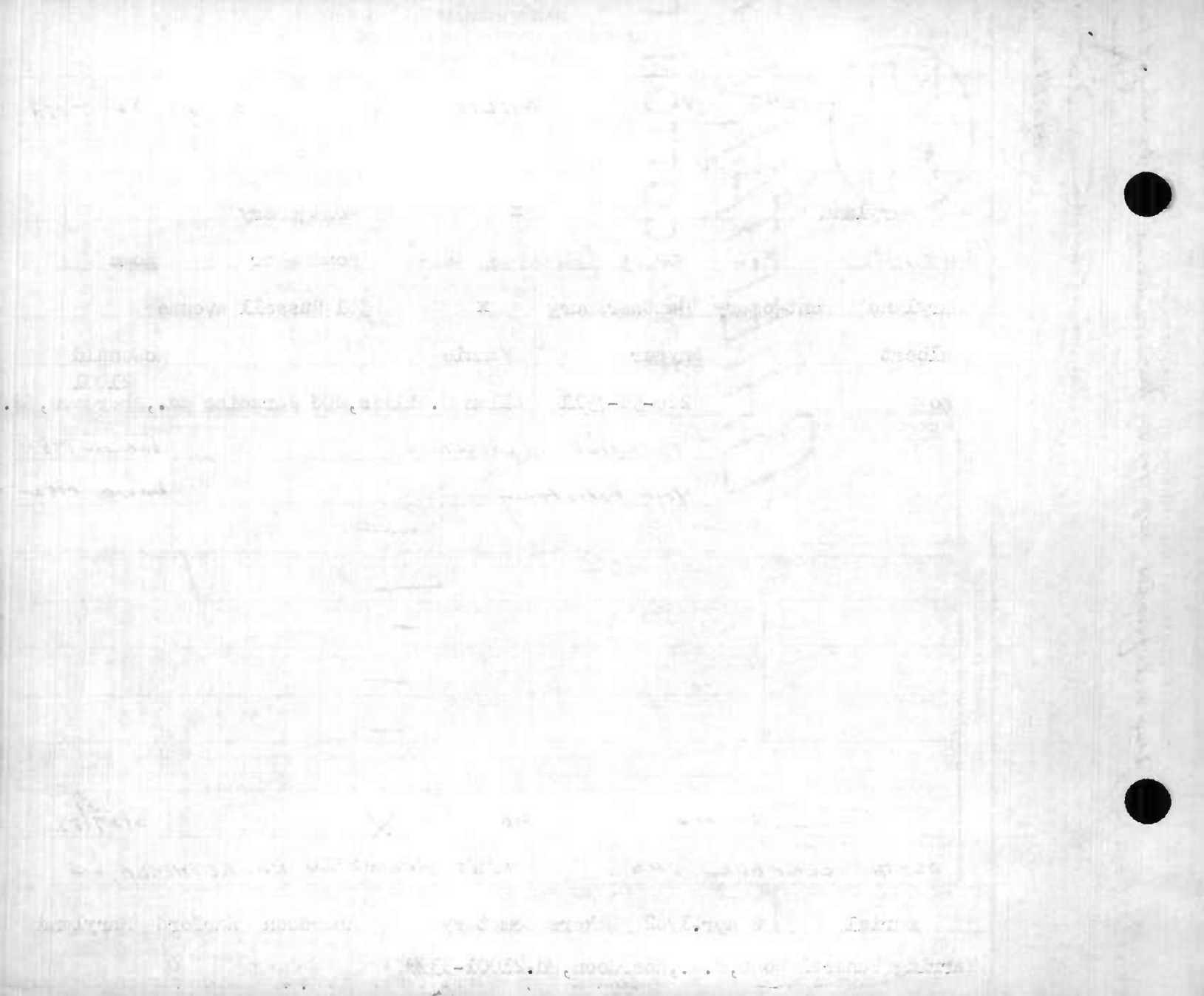
1. DECEASED NAME (TYPE OR PRINT) HELEN V. GILLIS			2a. DATE OF DEATH MONTH DAY YEAR 3 29 82			2b. HOUR 5:45 AM					
3. SEX F		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 2 10 23		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SPADY Grove Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 301 Russell Avenue		
14. FATHER'S NAME FIRST MIDDLE LAST Albert Snyder			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie McDonald			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 220-58-7511	
17. INFORMANT Allan W. Gillis			ADDRESS 208 Paradise Rd., Aberdeen, Md.			21001					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal septicemia 5699 DUE TO, OR AS A CONSEQUENCE OF (b) Post colectomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) —									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH March 1982 March 1982		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/29/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEKAGUL, MD			22e. ADDRESS 7425 ARLINGTON RD. BETHESDA, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2 Apr. 1982		23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland				
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md.			ADDRESS 21001-33			25a. DATE REC'D. BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death.
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 11 per phone 4/6/82 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 5 0 5

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AUDREY LAVINE GLASSMAN			2a. DATE OF DEATH MONTH DAY YEAR MARCH 30, 1982		2b. HOUR 6:42p.m.								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1925		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 56		7. UNDER 1 YEAR MONTHS DAYS 0 0		7. UNDER 24 HRS HOURS MIN. 0 0			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) H 6124 Overlea Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARTIST & TEACHER		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED					
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6124 Overlea Road	
14. FATHER'S NAME FIRST MIDDLE LAST BARNEY D. LAVINE						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN MENDELBOHM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES				16b. SOCIAL SECURITY NO. 153-20-9442				17. INFORMANT ADDRESS BERNARD S. GLASSMAN; 6124 Overlea Dr., Bethesda, Md.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic metastases DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of breast		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year 8 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from MARCH 19 81 , to JAN 19 82 , that (I) (we) lost saw the deceased alive on JAN 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JJ ANGLER MD				22e. ADDRESS DIV MEDICAL-ONCOL. GEORGETOWN UNIV HOSP WASH DC 20007			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/82		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Falls Church-Fairfax-Virginia		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. RECEIVED BY REGISTRAR APR 5 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

[Faint, mostly illegible handwriting at the top of the page, possibly containing a header or introductory text.]

Received of Mr. J. H. [illegible]
the sum of [illegible]
for [illegible]

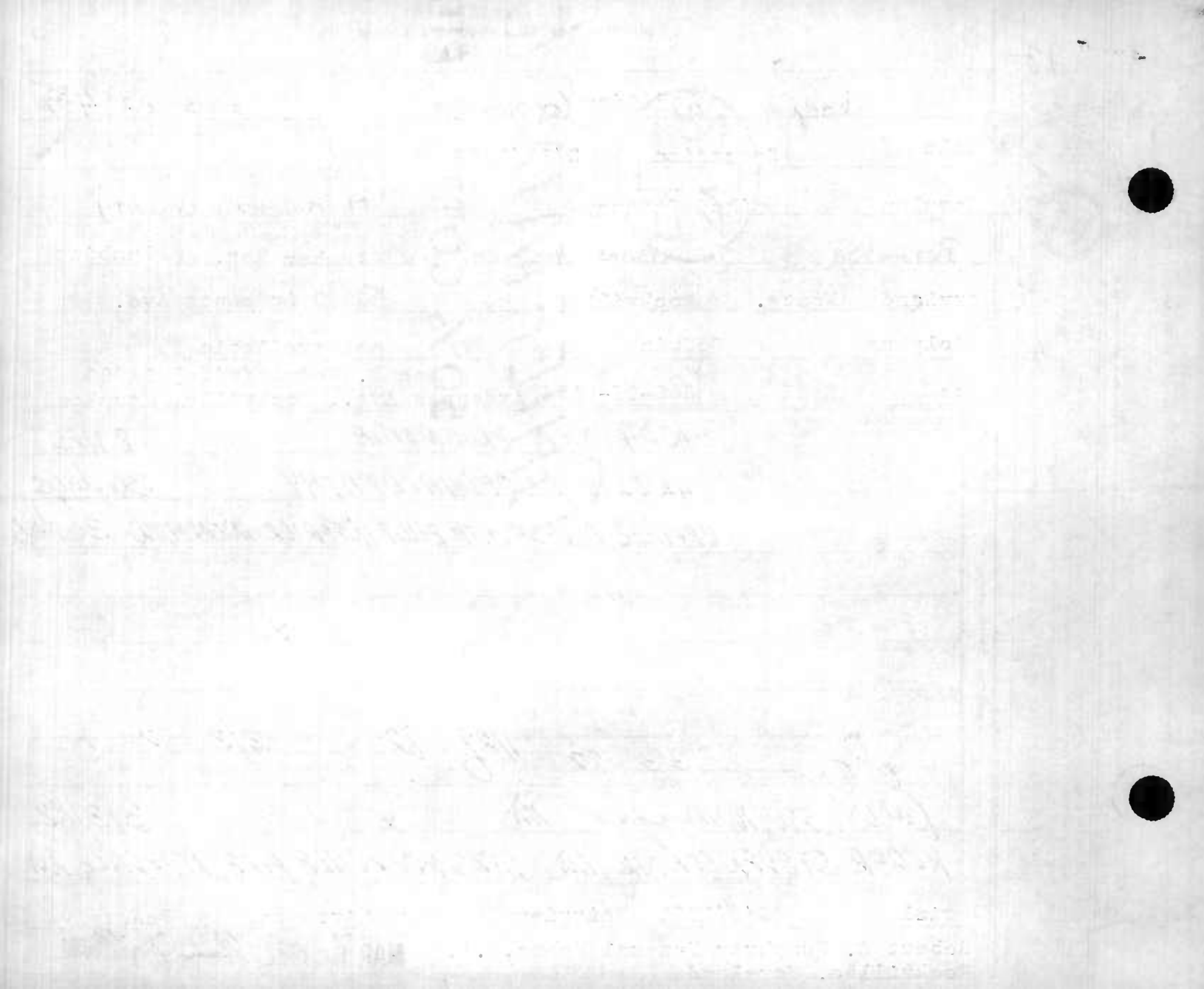
[Faint handwriting at the bottom of the page, likely a signature and date.]
J. H. [illegible]
[illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 5 0 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph William Godwin				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 3 - 3 - 82 4:35 P.M.			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8/17/1915		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 66 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber Ret.		12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Adolphus Godwin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST not available			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Rae B. Godwin(wife) 12900 Ardennes Ave., Rockville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ANOXIC ENCEPHALOPATHY 36 days DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARREST WITH ACUTE INFERIOR INFARCTION 36 days				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 HRS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/27 19 82 to 3/3 19 82 that (I) (we) lost 0 saw the deceased alive on 3/3 19 82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE Roger Stevenson, Jr. MD				22c. DEGREE MD		22d. DATE SIGNED 3/3/82	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, JR., MD				22f. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/1982		23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Artemas, Pennsylvania	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 8 1982			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8207507			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST			
ESTHER				GOLDBERG			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
DECEMBER 10, 1907		74		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6111 MONTROSE ROAD #1001	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY KOLODIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH ROTHSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN)		16b. SOCIAL SECURITY NO. 579-01-3458		17. INFORMANT 5450 S. No. Lake Shore Dr. DAVID R. GOLDBERG Chicago, Illinois 60657			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Congestive heart failure (b) Arteriosclerosis (c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1981, 19, to 3/19, 82, that (I) (we) last saw the deceased alive on 3/19/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOEL L. GOOZH, M.D.				22e. ADDRESS 4701 RANDOLPH ROAD, SUITE 105 ROCKVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/21/1982		23c. NAME OF CEMETERY OR CREMATORY BNAT ISRAEL CONGREGATION CEMETERY		23d. LOCATION CEMETERY OXON HILL, PR. GEORGES, MD.	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAR 24 1982			



Item 7a 8566 4/26/82 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 5 0 8

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) HENRIETTA GOLDEN			2a. DATE OF DEATH MONTH DAY YEAR 3 21 82			2b. HOUR 7 ¹⁰ P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 21 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8001 Blair Mill Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Rothstein Dental Lab.		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Saul					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella F. Polly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. -- 578-05-8430		17. INFORMANT ADDRESS 5539 Columbia Pike Arlington, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC C.V. DISEASE & HEART FAILURE 11 yrs</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> 19 <u>71</u> , to <u>3-21</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>3-21</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Bernard H. Ostrow</u>					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3-22-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD H. OSTROW					22e. ADDRESS 5225 Pooks Hill Rd Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/24/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY Brentwood Maryland			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.					P.O. Box 7428 Sil. Spr. Md.		25a. DATE RECEIVED BY POSTAL AUTHORITY MAR 24 1982			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 may be retained by the hospital or attending physician. Pages 1 and 2 should be filled within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3207509	
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Michael S. Goldstein										2b. HOUR 4:58 PM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1933		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS 48 YRS		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban				12a. USUAL OCCUPATION (TYPE OF WORK) Nat'l Director Contract Bridge League		12b. KIND OF BUSINESS OR INDUSTRY Card Game	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland				13b. CITY OR TOWN Montgomery				13c. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2941 Hewitt Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Barney Goldstein						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina Oshlag Labbate					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 077-26-7429				17. INFORMANT 115 Palm Dr. Box 122CCM Regina Goldstein Eustis, Florida 32726			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage - Esophageal Varices - 5712 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Hepatic Failure - c Acetates. (c) Cirrhosis of Liver -										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic Alcoholism -											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Ball				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED March 21, 1992			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 3-23-82		23c. NAME OF CEMETERY OR CREMATORY Georgetown Med. School			23d. LOCATION CITY OR TOWN Washington, D.C. STATE		
24. FUNERAL DIRECTOR NAME				ADDRESS				25. DATE REC'D BY REGISTRAR 3-26-1982			
Metropolitan Funeral Service; Alexandria, Va.											

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 5 1 0			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JUAN - GONZALEZ				2a. DATE OF DEATH MONTH DAY YEAR March 20, 1982			
3 SEX male				2b. HOUR 2:15P M			
4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Oct. 12, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Spain		7b. CITIZEN OF WHAT COUNTRY? Spain		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13533 Georgia Ave. #2		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Pedro Gonzalez				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Incarnacion R. Cabrera			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 96 7494		17. INFORMANT ADDRESS Matilda R. Gonzalez (wife) #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHOGENIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (c) ONE YEAR Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHRONIC OBSTRUCTIVE LUNG DISEASE							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DEC/17 19 81 , to MARCH 18 19 82 , that (I) (we) last saw the deceased alive on MARCH 18 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. A. Matheus, MD				DEGREE MD		22c. DATE SIGNED 3/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAFAEL A. MATHEUS				22e. ADDRESS 13018 GEORGIA AVE. WHEATON, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring	
24 FUNERAL DIRECTOR NAME W.W. Taltavull ADDRESS 4748 Wisc. Ave. N.W. Wash. D.C.							



CHRONIC OBSTRUCTIVE LUNG DISEASE
 BRONCHITIS
 CHRONIC RESPIRATORY FAILURE

CHRONIC OBSTRUCTIVE LUNG DISEASE

Weight 220 lbs Height 5'7"

Robert H. HATHING
 M.D. New York

1918 George H. HATHING

1918 George H. HATHING
 1918 George H. HATHING
 1918 George H. HATHING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR			8 2 0 7 5 1 1		
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD WOODLEIGH GOSLING			2a. DATE OF DEATH MONTH DAY YEAR MARCH 19, 1982		2b. HOUR 12:45 ^A M
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 25, 1925	6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ✓	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTE R, NIH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician	12b. KIND OF BUSINESS OR INDUSTRY Medical	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MONTANA			13b. CITY OR TOWN Thompson Falls	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS P.O. BOX 1214 59873
14. FATHER'S NAME FIRST MIDDLE LAST Walter W. Gosling			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel nmnn Coddington		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 151-18-9063	17. INFORMANT ADDRESS MRS. ANN P. GOSLING (NOK)		SAME AS ABOVE
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOBLASTOMA MULTIFORMIS (R) PARIETAL LOBE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CEREBRAL EDEMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA, SEVERAL SPLENIC ABSCESESSES</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 18, 1982</u> to <u>MARCH 19, 1982</u> , that (I) (we) lost saw the deceased alive on <u>MARCH 19, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas Sankh</i>		DEGREE MD		22c. DATE SIGNED 3/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas SANKH		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3-20-1982	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Geo, Md.
24. FUNERAL DIRECTOR W. W. Chambers Co, 8655 Georgia ave, S.S.			25a. DATE RECEIVED BY REGISTRAR MAR 30 1982		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Katherine W. Graves					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) KATHARINE W GRAVES					2a. DATE OF DEATH MONTH 3 DAY 15 YEAR 82			2b. HOUR 515 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 20 YEAR 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House Ret. & Nursing Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Bethesda					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6530 Democracy Boulevard		
14. FATHER'S NAME FIRST Charles MIDDLE Henry LAST Williamson					15. MOTHER'S MAIDEN NAME FIRST Emily MIDDLE Taylor LAST Glover				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 047-36-9989		17. INFORMANT ADDRESS Box 3034 Katharine G. Meredith - Annapolis, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 4402 IMMEDIATE CAUSE (a) Cardiopulmonary collapse DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death 1 hour 5 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) gangrene of right lower extremity									
19a. DATE OF OPERATION Sept 28		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED gangrene of right lower extremity			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>Sept 28</u> , 19 <u>76</u> , to <u>Mar 15</u> , 19 <u>82</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Henry Roth M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY ROTH, M.D.					22e. ADDRESS 8218 WISCONSIN AVE, BETHESDA, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/16/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland-Prince Geo. Co.-Md.			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Avenue, N.W.-Washington, D.C.					25a. DATE REC'D. BY REGISTRAR MAR 18 1982		25b. REGISTRAR'S SIGNATURE D. J. [Signature]		

17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 5 1 3			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MILDRED LORRAINE GREEN				2a. DATE OF DEATH MONTH DAY YEAR MARCH 17, 1982			
3. SEX FEMALE				2b. HOUR am 10:07 M			
4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR JULY 28, 1930		6. AGE (IN YEARS LAST BIRTHDAY) 51		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA 13b. COUNTY FAIRFAX 13c. CITY OR TOWN ALEXANDRIA				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST CECIL McMillan				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MILDRED LUVENIA TAYLOR			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 227-34-0052		17. INFORMANT FRANCES D. MARBURY: ALEXANDRIA, VA 22314			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: SQUAMOUS CELL CARCINOMA OF CERVIX IMMEDIATE CAUSE (a) 1809 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 01 MARCH 1982 , to 17 MARCH 1982 , that (I) (we) lost saw the deceased alive on 17 MARCH 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>S. Metz</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. METZ, LT, MC, USNR		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 22, 82		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Va.	
24. FUNERAL DIRECTOR <i>Tolson Greene</i>		Greene Funeral Home Alexandria, Va.		25a. DATE REC'D. BY REGISTRAR MAR 23 1982			

RECEIVED FOR DEPOSIT

11/11/1911



11/11/1911

John Brown

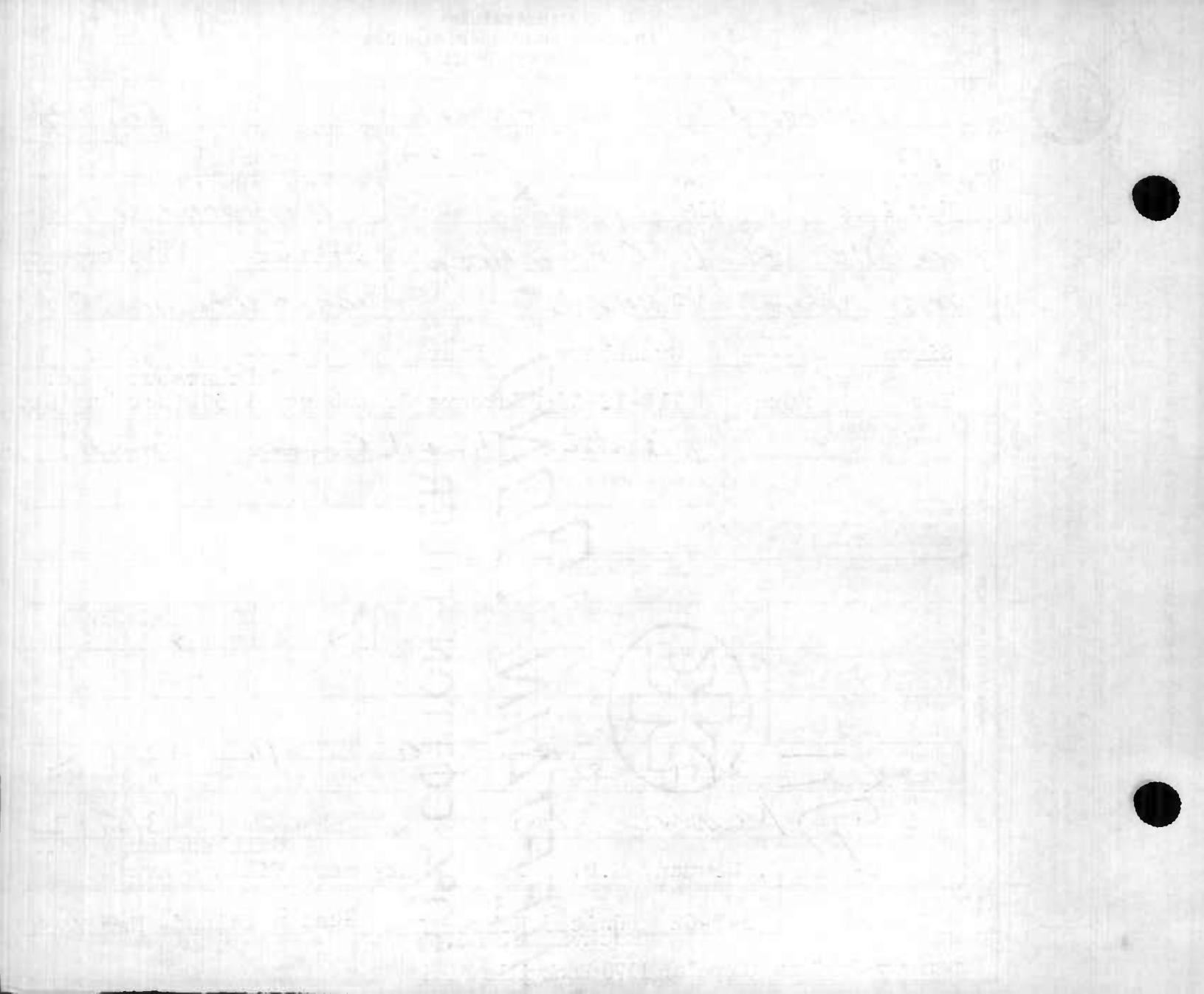
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 7 5 1 4			
FOR 1 - STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <i>Howard Greenberg</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>3 4 82</i>		2b. HOUR <i>1123</i> PM	
3. SEX <i>m</i>		4. RACE <i>Cauc</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 15 27</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>54</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Engineer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	
13a. STATE <i>MD</i>				13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Gaithersburg</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Simon ----- Greenberg</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Pearl ----- Weber</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>118-18-3683</i>		17. INFORMANT <i>Barbara Greenberg; 19508 Worsham Ct.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>1519</i> IMMEDIATE CAUSE (a) <i>metastatic Stomach Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>12</i> 19 <i>81</i> to <i>3/4</i> 19 <i>82</i> that (I) <i>(we)</i> last saw the deceased alive on <i>2/19</i> 19 <i>82</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(I have)</i> <i>(did not)</i> view the body after death.							
22b. SIGNATURE <i>Stephen J. Newman</i> MD 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Stephen J. Newman, M.D.</i>				22c. ADDRESS <i>19261 Montgomery Village Ave;</i>		22c. DATE SIGNED <i>3/5/82</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>3-7-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>United Hebrew Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Staten Island New York</i>	
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 10 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 7 5 1 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) SARA J. GROSSMAN				2a. DATE OF DEATH MONTH DAY YEAR MARCH 2 82 2b. HOUR 10:40AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 14, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY DRESS SHOP	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JACOB GROSSMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-32-4731		17. INFORMANT ADDRESS MRS. RUTH G. GROSS, 1133 S. W. 13th PLACE BOCA RATON, FLORIDA			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Bilateral Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6/30 19 81 to 3/2 19 82 that (I) (did) lost saw the deceased alive on 3/2 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (will) (did not) view the body after death.							
22b. SIGNATURE K. H. SHAH		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. SHAH MD		22e. ADDRESS 6105 Montrose Rd. Rockville					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 3/4/1982		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA	
24. FUNERAL HOME DONALD C. STEIN HEBREW MEMORIAL FUNERAL HOME				25. BY REGISTRAR SIGNATURE			
232 CARROLL STREET, N. W., WASHINGTON, D. C.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after a death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 0 7 5 1 6

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herman Dietrich Gunther			2a. DATE OF DEATH MONTH DAY YEAR March 6, 1982			2b. HOUR 7:15PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer Dupont Co.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Johann Gunther				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Ellerbrock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17. INFORMANT ADDRESS Jean Gunther, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypoxemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Pneumonia</u> 24 hours 4 days							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Prostatic hypertrophy</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 14, 1980</u> to <u>Feb. 25, 1982</u> , that (I) (we) lost saw the deceased alive on <u>Feb. 25, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Christopher Unger</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger, M.D.				22e. ADDRESS 8218 Wisconsin Ave. Bethesda, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 10, 1982		23c. NAME OF CEMETERY OR CREMATORY Millbrook Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Randolph Twp. New Jersey	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR MAR 15 1982		25b. REGISTRAR'S SIGNATURE <u>James Van Natten</u>	

